

1 Item 18 Film G377 6/6 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06904

CERTIFICATE OF DEATH

06895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
Frederick County MARYLAND		Rural - Frederick		13 days		a. STATE MARYLAND b. COUNTY FREDERICK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Rural - Frederick		10-1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Frederick Memorial Hospital								
d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JAMES	Middle EMMERT	Last ANGLEBERGER	4. DATE OF DEATH	Month MAY	Day 26	Year 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/7/54	9. AGE (In years last birthday) 11 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Deyrs	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME Emmert ANGLE BERGER		14. MOTHER'S MAIDEN NAME SARAH O'Brien		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		
17. INFORMANT Emmert F. Angleberger-Route 6-Frederick-Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH APPROX 12 days		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MENINGOENCEPHALITIS		DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Mycobacterium tuberculosis		
0021		DUE TO				(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from MAY 11, 1966, to MAY 26, 1966, that (I) (we) last saw the deceased alive on MAY 26, 1966, and that death occurred at 12 <sup>th</sup> M, from the causes and on the date stated above.								
22a. SIGNATURE J. Fred Baker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. J. Fred Baker				22d. ADDRESS		22b. DATE SIGNED May 26, 1966		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30-1966		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701		
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Whitmore		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Bp		Frederick, Md. 21701		MAY 31 1966		j Charles Judge		



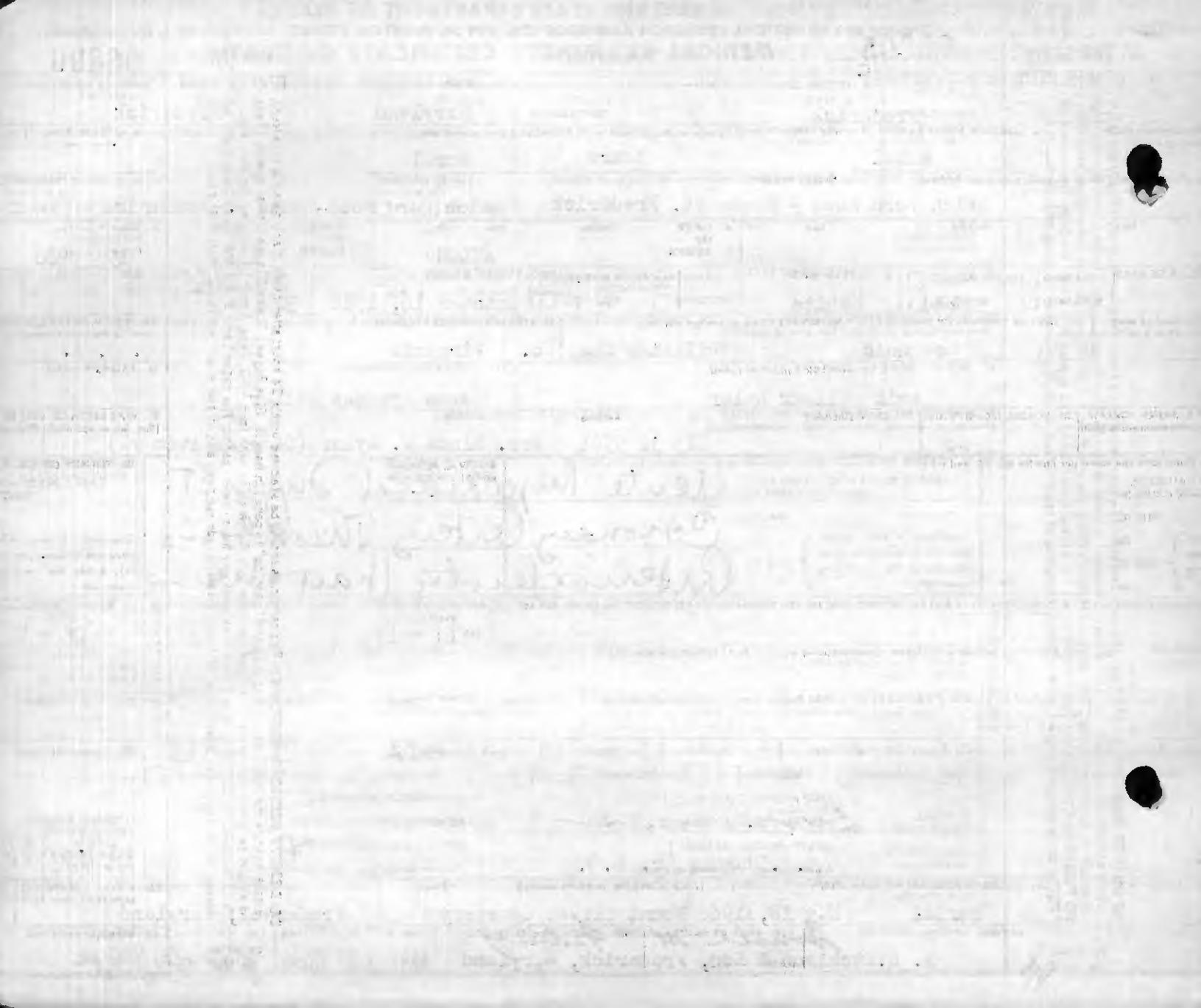
**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN lb <b>Years</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reich Ford Road - Route #6, Frederick</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		f. STREET ADDRESS <b>Reich Ford Road-Route #6, Frederick</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hillside Coal Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Lewis Wilmer Aylor</b>		14. MOTHER'S MAIDEN NAME <b>Maude Frances Miller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. <b>223 32 9501</b>		17. INFORMANT <b>Mrs. Linda M. Aylor (Same as item #2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4261 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b)  DUE TO (c)		Acute Myocardial Infarct Coronary Artery Thrombosis Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O.Thomas</b>		EXAMINER'S NAME (Type) <b>B.O.Thomas Sr. M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>15 May 66</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1966</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR <b>Donald M. Fudley</b>		ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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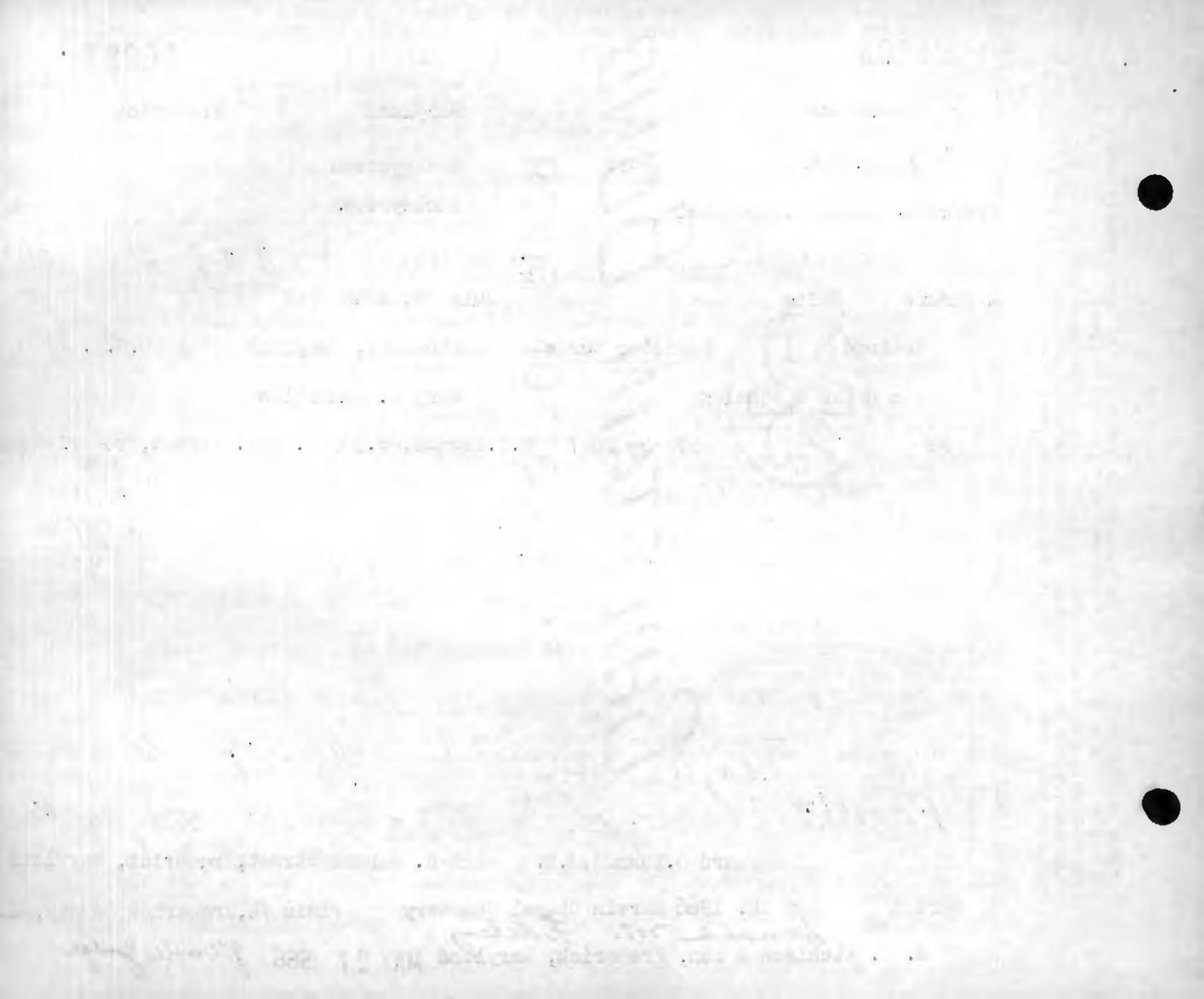
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1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06906

CERTIFICATE OF DEATH

06897

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, II Institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 <b>Frederick</b> Days		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georgetta</b>	First	Middle	Last
4. DATE OF DEATH <b>Bartholow</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1896</b>
9. AGE (In years last birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Register Nurse</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bartholows, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Banks Bartholow</b>	14. MOTHER'S MAIDEN NAME <b>Mary G. Gambrills</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>579 48 9647</b>	17. INFORMANT <b>B.O.Thomas, Jr.</b>	Address <b>305 W. 2nd. Street, Frederick, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Woman</b> 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pyelonephritis</b> -DUE TO 2. <b>Arterio / sclerotic C.I.D.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary fibrosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1, 1960</b> to <b>May 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 21, 1966</b> , and that death occurred at <b>TP</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard O. Thomas, Jr.</b>		22b. DATE SIGNED <b>May 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>228 N. Market Street, Frederick, Maryland</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Marvin Chapel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Plain #4, Frederick County, Md.</b>
24. FUNERAL DIRECTOR <b>Donald M. Fideler</b>	25a. ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	25b. REC'D BY REGISTRAR <b>MAY 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06898

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy 06-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial		d. STREET ADDRESS 304 Park Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herman S. Beck, Sr.		4. DATE OF DEATH Month Day Year May 26 1966	
First Middle Last			
5. SEX M 6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED Sept. 20, 1891	
9. AGE (In years (last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Owner		10b. KIND OF BUSINESS OR INDUSTRY Chicken Hatchery Carroll Co., Md.	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Beck		14. MOTHER'S MAIDEN NAME Mary Ebbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1		16. SOCIAL SECURITY NO. 217-12-1786 17. INFORMANT Mrs. Marie L. Beck	
		Address Mt. Airy, Md. 304 Park Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO OUE TO (c)		15 minutes 2-3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While p.m. at work at work		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1966</u> to <u>May 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1966</u> , and that death occurred at <u>11A M</u> , from the causes and on the date stated above.		22d. DATE SIGNED 27 May 66	
22a. SIGNATURE Henry V. Chase M.D.		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4E Church St Frederick Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/30/1966 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Messiah Lutheran Cemetery Sykesville, Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR JUN 1 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

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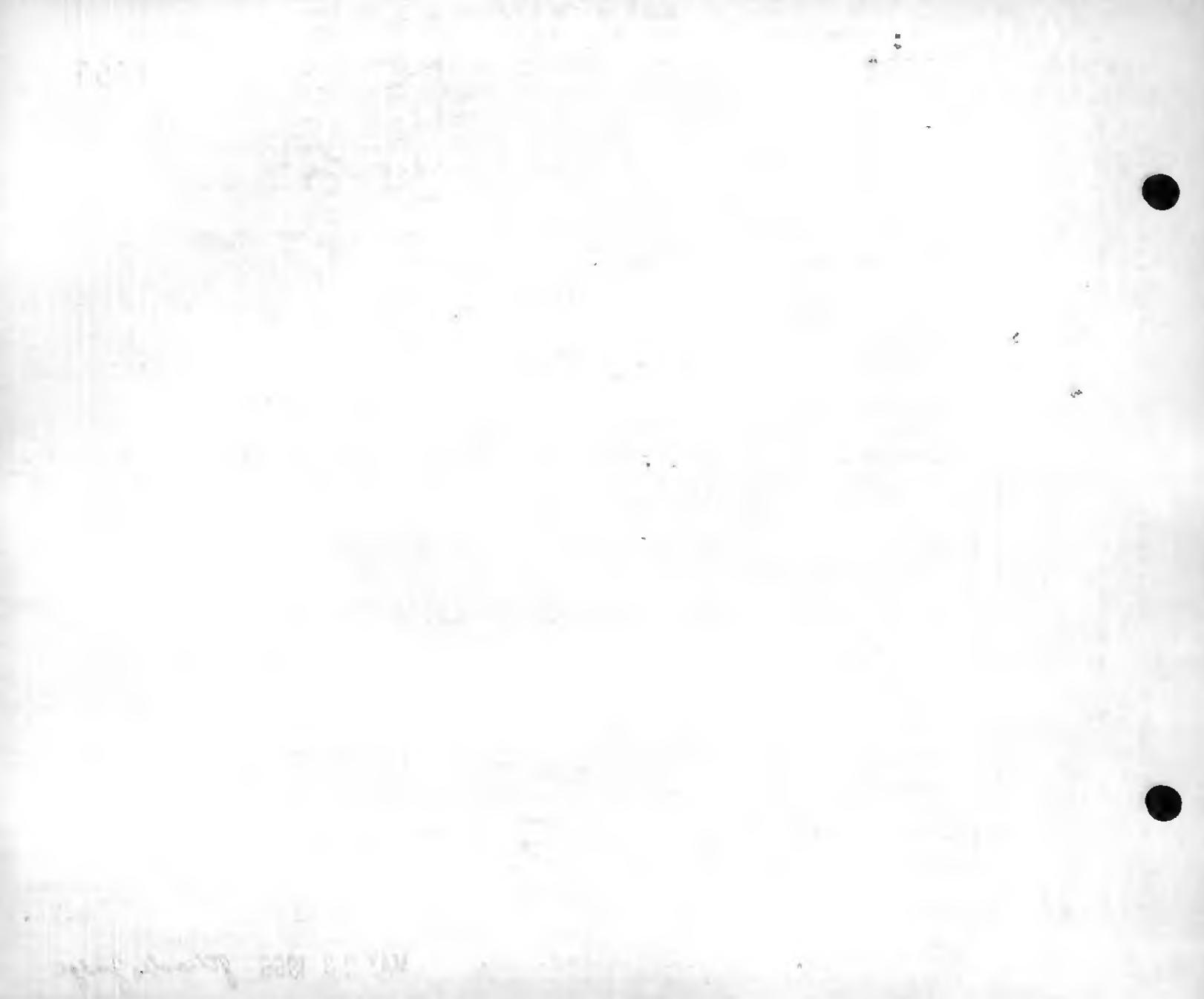
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06899

1. PLACE OF DEATH Frederick COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland STATE b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burdock Heights		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burdock Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Clyde	Middle Wayne	Lost Biddle	4. DATE OF DEATH	Month May Doy 18 Year 1966
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years l/m/b/d/o) 56 yrs.
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	Nov. 3, 1909	IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fred. Construction		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Ingle Biddle			14. MOTHER'S MAIDEN NAME Sarah Ann Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 232-26-9728		17. INFORMANT Raymond Biddle Address Braddock Heights, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH					
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteroclotis Heart Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/18/66	
EXAMINER'S NAME (Type) B.O. Thomas M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF May 21, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Woodside Memorial	
23d. LOCATION (City or Town) Grafton		(County)		(State) W.Va.	
24. FUNERAL DIRECTOR Gladhill Co.		ADDRESS Middletown, Md.		25a. REC'D BY REGISTRAR DA MAY 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1  
C6903

## CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 1. PLACE OF DEATH

COUNTY  
Frederickb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Frederick

MARYLAND

c. LENGTH OF STAY IN IS  
2 MOS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)First  
WalterMiddle  
S.

5. SEX

Male

6. COLOR OR RACE  
White7. MARRIED  
WIDOWEDNEVER MARRIED  
DIVORCEDLast  
Bidle Sr.4. DATE  
OF  
DEATHMonth  
MayDay  
16  
Year  
19668. DATE OF BIRTH  
April 6, 18859. AGE (In years  
at birthday)  
81  
yrs.10. IF UNDER 1 YEAR  
Months  
Days11. IF UNDER 24 HRS.  
Hours  
Min.10a. USUAL OCCUPATION (Give kind of work  
done, duration of work, even if retired)  
Retire Farmer10b. KIND OF BUSINESS OR INDUSTRY  
Own Farm11. BIRTHPLACE (County & State, or foreign country)  
Maryland12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William A. Bidle

14. MOTHER'S MAIDEN NAME  
Laura Summers15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war duties of service)  
NO16. SOCIAL SECURITY NO.  
215-20-8574

17. INFORMANT

Address

Glenn W. Bidle Middletown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

7201

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute coronary thrombosis  
atherosclerotic Heart DiseaseINTERVAL BETWEEN  
ONSET AND DEATHminutes  
years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1965, to May 16, 1966, that (I) (we) last saw the deceased alive on May 15, 1966, and that death occurred at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE

Henry V. Chase  
M.D.ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.

22d. ADDRESS

Frederick, Maryland

22b. DATE  
SIGNED  
17 May 66

23a. BURIAL, CREMATION, (Specify)

Burial

23b. DATE THEREOF  
May 19, 1966

23c. NAME OF CEMETERY OR CREMATORIAL

Lutheran Cemetery

23d. LOCATION (City, town or county)

Middletown

(State)  
Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Gladhill Co.

ADDRESS  
Middletown, Md.

25a. REC'D BY REGISTRAR

MAY 19 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



AM  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

66910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. If you need pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and have a need within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN b. MARYLAND 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 411 Biggs Avenue		d. STREET ADDRESS 411 Biggs Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10-1	
3. NAME OF DECEASED (Type or print) RICHARD		4. DATE OF DEATH Month Day Year May 18, 1966	
First MIDDLE Last		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1928	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Deyrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientist U.S. Govt.		11. BIRTHPLACE (State or foreign country) Columbus, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rebah Bowman	
14. MOTHER'S MAIDEN NAME Sarah Townsend		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 284-24-2537		17. INFORMANT Mrs. Emma Jane Bowman 411 Biggs Ave. Fred. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Carbon Monoxide intoxication	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Piped exhaust into closed car	
20c. TIME OF INJURY Month, Day, Year May 18, 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, term., factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Frederick - Frederick - Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
ACTUAL SIGNATURE B.O. Thomas		DATE SIGNED May 18, 1966	
EXAMINER'S NAME (Type) B.O. Thomas Sr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAY 20 1966	
22c. NAME OF CEMETERY OR CREMATORIAL Columbus, Ohio		22d. LOCATION (City, town, or county)	
23. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR MAY 20 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
C6911 CERTIFICATE OF DEATH 06902															
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
Frederick MARYLAND						a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b									
Frederick						5 days									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)															
Frederick Memorial Hospital															
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year				
Female			Fannie Martha	Daisey	Brandenberg	March 29, 1882			84	1	66				
5. SEX			6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)				10. IF UNDER 1 YEAR Months Days Hours Min.			
Female			White		WIDOWED	<input checked="" type="checkbox"/>	DIVORCED	84 yrs.				U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife				Own Home				Frederick, Maryland				U.S.A.			
13. FATHER'S NAME															
Joesphus Wise															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
No				216-54-8285				Marshall Brandenberg, Middletown							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke, myocardial infarction</i>															
331X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis, heart disease.</i>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				20f. (City or town) (County) (State)			
19															
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1964 to <i>5/26, 1964</i> , that (I) (we) last saw the deceased alive on <i>3/30, 1964</i> , and that death occurred at <i>3:15 P.M.</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>James B. Thomas</i>															
22b. DATE SIGNED															
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
James B. Thomas M.D.												22d. ADDRESS			
												Frederick, Maryland			
23a. BURIAL, CREMATION, REMDVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town or county) (State)			
Burial				June 2, 1966				Reform Cemetery				Middletown, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Gladhill Company, Middletown, Md.								JUN 3 1966				Charles Judge			
VR A15 (4) 2DM 1/65															



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the attending physician or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06903	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
Frederick MARYLAND			a. STATE Maryland b. COUNTY Montg.										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)										
Frederick Hrs.			Beallsville										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS										
Frederick Memorial Hospital			*****										
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Eva Heskett					BUXTON	May	17	1966					
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Hours	13. MIN.			
Female White			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 7 1902	63 yrs.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
Housewife			Own home			Virginia							
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME										
Irving Heskett			Viola E. Wilt										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No						Mrs. Estelle Williamson Beallsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u>													
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
19													
21. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 1966, to <u>5/17</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/17</u> 1966, and that death occurred at <u>1570</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard C. Reynolds</u>													
22b. DATE SIGNED													
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS				
Richard C. Reynolds													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county) (State)				
Burial			5/20/66			New Jerusalem			Lovettsville Va.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Constance C. Hilton Barnesville, Md.						MAY 23 1966			Charles Judge				
VR A15 (4) 20M 1/65													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C6913

CERTIFICATE OF DEATH

06904

1. PLACE OF DEATH  
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

MARYLAND

c. LENGTH OF STAY IN 1b

2 weeks

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Lynne Nursing Home

3. NAME OF  
DECEASED  
(Type or print)

First Middle Last  
Sarah ELIZABETH CLEM

4. DATE  
OF  
DEATH

MAY

14

1966

5. SEX

F.

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Jan. 1, 1875

9. AGE (In years  
last birthday)

91 yrs.

10. IF UNDER 1 YEAR  
Months Dey

11. IF UNDER 24 HRS.  
Hours Min.

10a. DURESS OCCUPATION (Give kind of work done during most of working life, even if retired)

Dressing Poetry

10b. KIND OF BUSINESS OR INDUSTRY

Poultry Farm

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Phillip Morningstar

14. MOTHER'S MAIDEN NAME

Mary King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

214-34-0579

17. INFORMANT

Mr. L. Michels, Elmer, Frederick, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a)

Cerebro vascular Thrombosis

44.5 X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Hypertensive cardio vascular disease

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

4 WKS

20-30 yr.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING

CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 17, 1966, to MAY 14, 1966, that (I) (we) last saw the deceased alive on MAY 1st, 1966, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Ralph L. Michels

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

MAY 16, 66

22b. DATE  
SIGNED

22c. PHYSICIAN'S  
NAME (Type)

Ralph L. Michels

22d. ADDRESS

Medical Center, Frederick, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/17/66

23c. NAME OF CEMETERY OR CREMATORI

Utica

23d. LOCATION (City, town or county)

Utica

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Y. C. Barton, Walkersville, Md.

ADDRESS

25a. REC'D BY REGISTRAR  
DATE

MAY 20 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

6914

## CERTIFICATE OF DEATH

06905

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>WALTER</b>		First <b>WALTER</b>	Middle <b>SAMUEL</b>
4. DATE OF DEATH <b>3/18/1966</b>	Month <b>5</b>	Day <b>12</b>	Year <b>1966</b>
5 SEX <b>M.</b>	6 COLOR OR RACE <b>W.</b>	7. MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>3/18/1903</b>
9 AGE (In years last birthday) <b>63</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Retired employee Washington Terminal</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Florence Joseph Donovan</b>	14. MOTHER'S MAIDEN NAME <b>Grace Estella Wilson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO <b>718-18-0127</b>	17. INFORMANT <b>Water R. Donovan</b>	Address <b>Brunswick Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Primary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced generalized atheros -</b> DUE TO <b>Myo.</b> (c) <b>atherosclerosis.</b>			
19. WAS A TROPY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5-12-1966</b>
20f. (City or town) <b>Brunswick</b>		(County) <b>Maryland</b>	
(State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>5-12-1966</b> to <b>5-17-1966</b> , that (I) (we) last saw the deceased alive on <b>5-12-1966</b> , and that death occurred at <b>7:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>5-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.E. Pruitt M.D.</b>		22d. ADDRESS <b>Brunswick Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/16/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) <b>Petersville</b>
24. FUNERAL DIRECTOR <b>Teete Funeral Home</b>		25a. ADDRESS <b>Brunswick, Md.</b>	25b. REC'D BY REGISTRAR <b>MAY 17 1966</b>
		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**C 6915**

**CERTIFICATE OF DEATH**

**06906**

1. PLACE OF DEATH  
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

R#7

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montevue Infirmary

3. NAME OF  
DECEASED  
(Type or print)

First

MARYLAND

c. LENGTH OF STAY IN 1b

3 mo & 13 days

5. SEX

6. COLOR OR RACE

M.

W.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

7. MARRIED  NEVER MARRIED

b. DATE OF BIRTH

Sept 10, 1903

9. AGE (In years last birthday)

62 yrs.

10. IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Year

Hours

Min.

13. FATHER'S NAME

IRVING DUDREAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

4-5-1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

219-14-8132 MRS. KENNETH STRAUBSBURG R#1

Recurrent cerebral (cerebral) accident

INTERVAL BETWEEN  
ONSET AND DEATH  
24 hours

Arteriosclerotic cardiovascular disease

4 years.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 20d. INJURY OCCURRED  
p.m. 19 While  Not While   
at work  at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 6, 1966 to May 18, 1966, that (I) (we) last saw the deceased alive on May 18, 1966, and that death occurred at 6:00 PM, from the causes and on the date stated above.

22a. SIGNATURE

Le Roy T. Davis

M.D.

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS.

22b. DATE SIGNED  
5/19/66

22c. PHYSICIAN'S NAME (Type)

LEROY T DAVIS

22d. ADDRESS

FREDERICK MD

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

BURIAL

5/21/66

FAIRMOUNT LIBERTYTOWN MD

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Dr Hartzler & Sons Libertytown Md

MAY 23 1966 Charles Judge



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																
CERTIFICATE OF DEATH																
06316						06907										
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY Frederick			a. STATE Maryland													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			b. COUNTY Frederick													
c. LENGTH OF STAY IN 1b 6 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 904 Pontiac Avenue													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) First Harry Middle Baker Last S.A. 4. DATE OF DEATH			Month MAY Day 8 Year 1966													
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH October 5, 1891			9. AGE (In years last birthday) 74 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Electrician			11. BIRTHPLACE (County & State, or foreign country) Jim Town, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Eicholtz			14. MOTHER'S MAIDEN NAME Almeda Wolfe													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-10-3050 A			17. INFORMANT Kenneth L. Eicholtz, 904 Pontiac Ave.			Address Frederick, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral Infarction									INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)			Cerebral Arteriosclerosis										
			DUE TO (c)			Congestive Heart Failure										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			Arteriosclerosis & Hypertensive Heart Disease									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Frederick, Maryland			(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 1958, to May 8, 1966, that (I) (we) last saw the deceased alive on May 7, 1966, and that death occurred at 11:25 AM, from the causes and on the date stated above.												22b. DATE SIGNED May 8, 66				
22a. SIGNATURE R. L. Michels			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
22c. PHYSICIAN'S NAME (Type) R. L. Michels, M. D.			22d. ADDRESS Frederick Medical Center, Frederick, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 11, 1966			23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery			23d. LOCATION (City, town or county) Frederick, Maryland			(State)				
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland			ADDRESS Frederick, Maryland			25a. REC'D BY REGISTRAR MAY 11 1966			25b. REGISTRAR'S SIGNATURE Charles J. Juge							



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

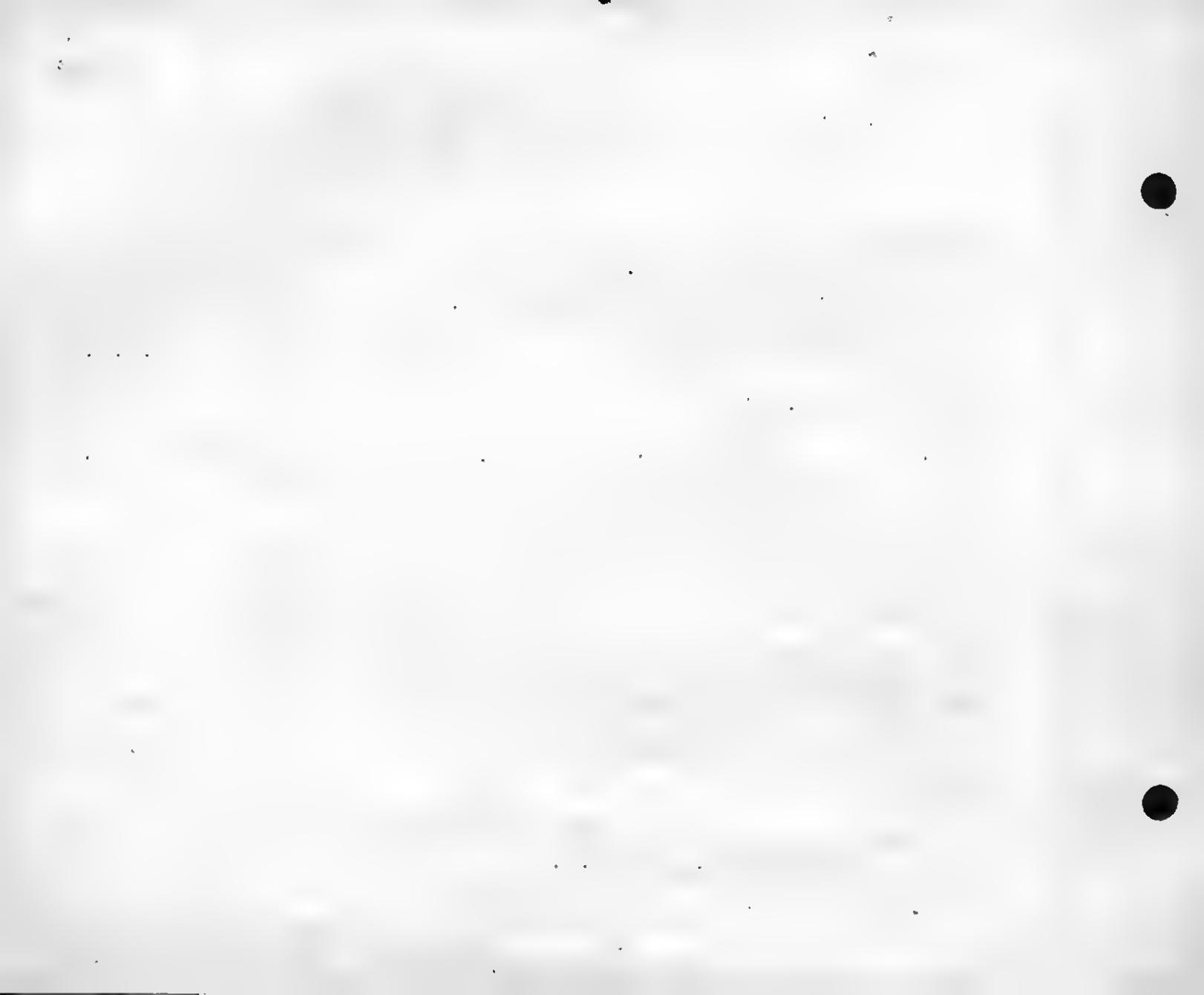
101  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~any~~ event, within 72 hours after death.

06917

## CERTIFICATE OF DEATH

06908

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Creagers town</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROY</b>		First	Middle <b>M.</b>	Last <b>FISHER</b>	4. DATE OF DEATH <b>May 6 1966</b>	Month	Day	Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1898</b>	9. AGE (in years last birthday) <b>67 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.</b>			
13. FATHER'S NAME <b>Frederick C. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Colliflower</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-8823</b>		17. INFORMANT <b>Rufael</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <b>Arteriosclerosis</b>	DUE TO (c) <b>Diabetes</b>						20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 1966</b> to <b>May 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>5-3 1966</b> and that death occurred at <b>8A M</b> , from causes and on the date stated above.									
22a. SIGNATURE <i>Thomas A. Love M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/6/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>THOMAS A. LOVE M.D.</b>		22d. ADDRESS <i>Thurmont Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Creagers town Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Creagers town Md.</b>			
24. FUNERAL DIRECTOR <i>Raymond Creager Thurmont Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 20 M 1/66				DATE <b>MAY 10 1966</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

66918

## CERTIFICATE OF DEATH

06909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Leevistown</i>		b. COUNTY <i>Maryland</i>			
c. LENGTH OF STAY IN 1b <i>14 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Leevistown</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>		d. STREET ADDRESS <i></i>			
3. NAME OF DECEASED (Type or print) <i>Mary Iola</i>		First	Middle		
4. DATE OF DEATH Month Day Year <i>5 16 1966</i>		Month	Day		
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22, 1883</i>		
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Lewis A. Gilbert</i>			
14. MOTHER'S MAIDEN NAME <i>Hattie Elder</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Russell Fox, Frederick, P.O. Box 100, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cor pulmonale</i>		30b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pulmonary emphysema</i>			
DUE TO (c) <i>Pulmonary emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) <i>Frederick, Md.</i> (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5/17</i> , 1966, to <i>5/16</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/14</i> , 1966, and that death occurred at <i>5:50 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>James B. Thomas</i>		22b. DATE SIGNED <i>5/17/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES B. THOMAS</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>Professional Bldg., Fred., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/19/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Brookhill Cem.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.C. Barton, Walkersville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 20 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CC913

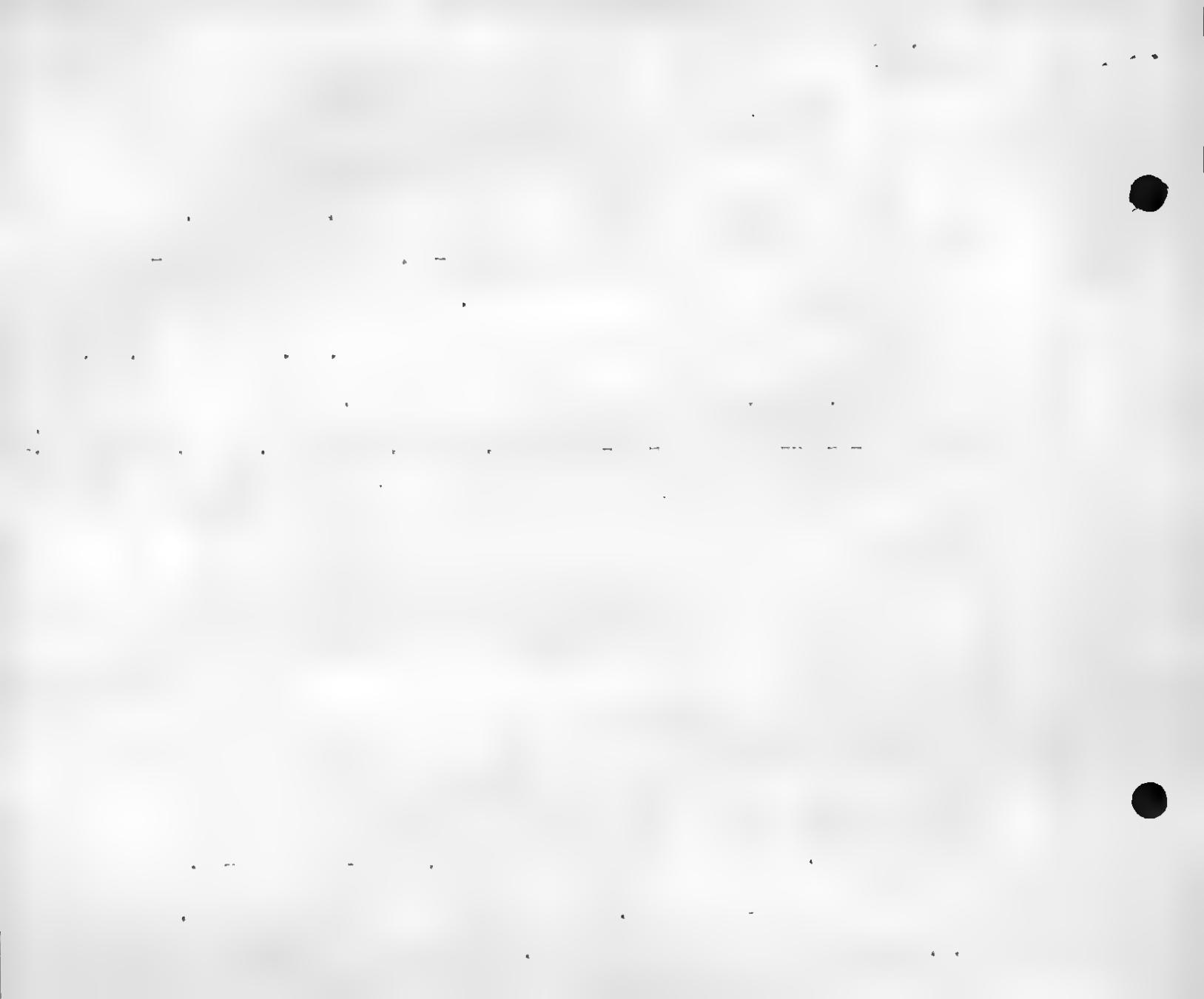
06910

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
Frederick MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Years	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 417 E. Patrick St.	
3. NAME OF DECEASED (Type or print)	First Lawrence	Middle Xavier	Last Gouker-Sr.
4. DATE OF DEATH	Month May	Day 24-	Year 19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	Jan. 23- 1898	9. AGE (in years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Electrick Railway	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Gouker		14. MOTHER'S MAIDEN NAME Minnie E. Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214- 10- 5884	
17. INFORMANT Mrs. Mary J. Gouker-Sr.		Address Frederick-Md. 417 E. Patrick St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Lung</i> X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ DUE TO _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While _____ Not While _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 24, 1966</i> , to <i>May 24, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 24, 1966</i> , and that death occurred at <i>417 E. Patrick St., Frederick, Md.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>James B. Thomas</i>		22b. DATE SIGNED <i>5-24-66</i>	
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Prof. Bldg. -Frederick-Md. 21701
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick-Md. 21701	
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Frederick-Md. 21701		MAY 31 1966	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06911

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 12 hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS E. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Warner T.				Grimes	May 2 1966
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Sept. 1878	9. AGE (In years, last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Warner T. Grimes		14. MOTHER'S MAIDEN NAME Sarah Hessong			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NC		17. INFORMANT Mrs. Mary Huebener	
				Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis with hemiplegia</i>   INTERVAL BETWEEN 332X   DUE TO   ONSET AND DEATH Conditions, if any, which   (b) <i>Cerebral atherosclerosis</i>   48 hrs gave rise to immediate   DUE TO   yrs cause (a), stating the   (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966, to May 2, 1966, that (I) (we) last saw the deceased alive on May 1, 1966, and that death occurred at 12:40 M, from the causes and on the date stated above.					
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 2 May 66			
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 4 E. Church St Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-66		23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem.	
23d. LOCATION (City, town or county) Thurmont		(State) Fred. Co. Md.			
24. FUNERAL DIRECTOR Raymond E. O'Connor		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR MAY 5 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

CC921

## CERTIFICATE OF DEATH

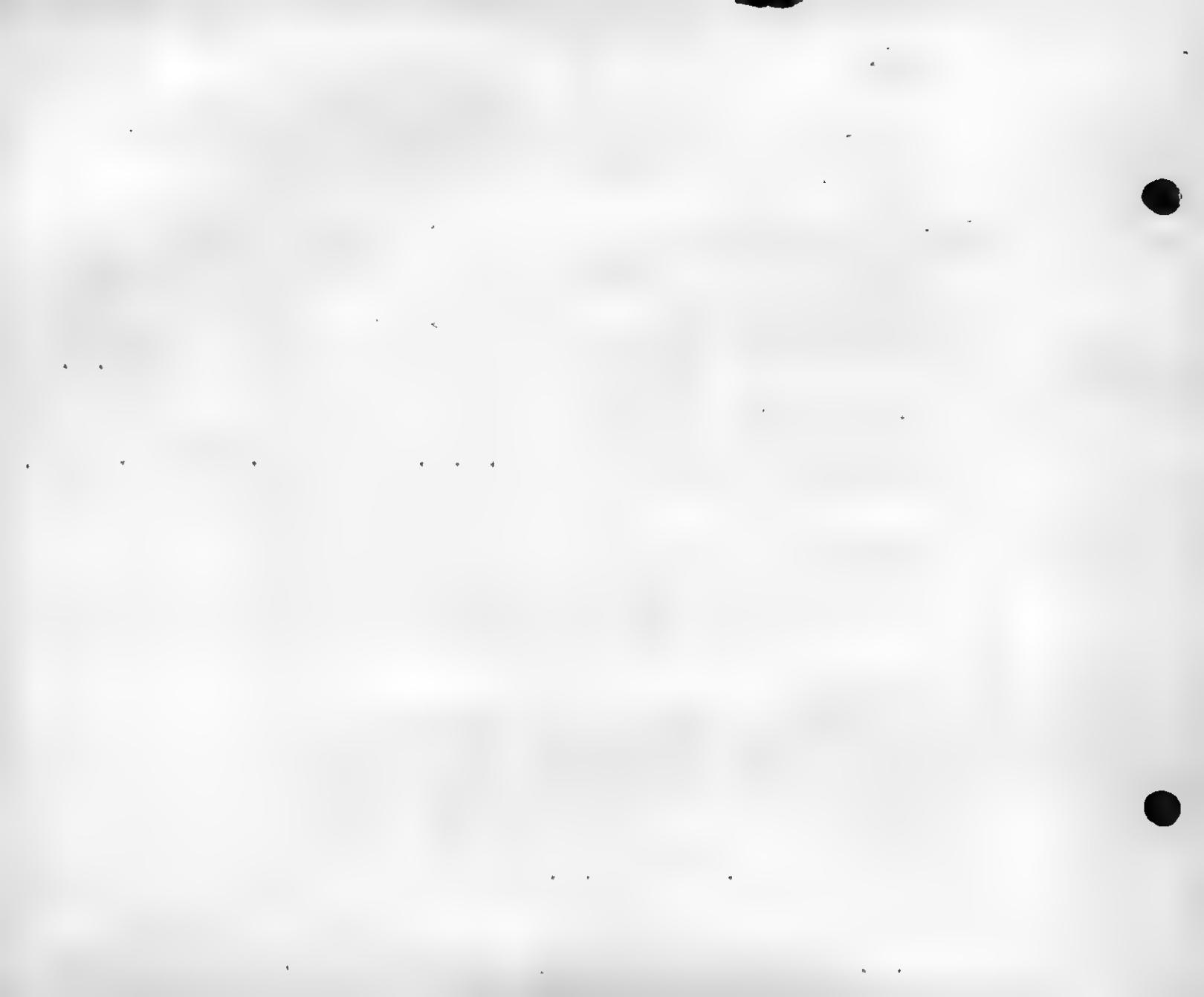
06912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Nursing Center</b>			d. STREET ADDRESS <b>434 N. Market Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Naomi</b> First <b>Kathleen</b> Middle		4. DATE OF DEATH <b>May 26, 1878</b>		Month <b>May</b>	Day <b>11</b>	Year <b>19 66</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input checked="" type="checkbox"/>	9. AGE (in years last birthday) <b>87 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. DAYS <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Musician</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro, Maryland</b>		
13. FATHER'S NAME <b>Augustus Gring</b>			14. MOTHER'S MAIDEN NAME <b>Alice Stonebraker</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>219 30 3473</b>		17. INFORMANT Address <b>Mrs. W. S. Baker, 434 N. Market St. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, bronchial, terminal</b> INTERVAL BETWEEN ONSET AND DEATH 2 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Insufflation</b> 3 mos. DUE TO (c) <b>Cerebral arteriosclerosis</b> Severe 1						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ur. via; Recent mild Cerebral Vascular Accident</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frederick</b>	(County) <b>Md.</b>	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/11/66</b> to <b>5/11/66</b> that (I) <b>we</b> lost saw the deceased alive on <b>5/11/66</b> 19 <b>19</b> , and that death occurred at <b>2:00 p.m.</b> from causes and on the date stated above.						
22a. SIGNATURE <i>Gilcin F. Meadors</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>May 12, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gilcin F. Meadors, M. D.</b>		22d. ADDRESS <b>Toll House Avenue, Frederick, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 13, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>		
24. FUNERAL DIRECTOR <i>Donald M. Etchison</i>		ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1 FOR STATE  
HEALTH DEPT.  
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6922

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06913

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5-7 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Highway</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
						a. STATE <b>Maryland</b>	b. COUNTY <b>Frederick</b>		
						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural</b>			
						d. STREET ADDRESS <b>Route #2, Mt. Airy</b>			
3. NAME OF DECEASED (Type or print) <b>DONALD RAY HAMILTON Sr.</b>		First <b>DONALD</b>	Middle <b>RAY</b>	Last <b>HAMILTON Sr.</b>	4. DATE OF DEATH <b>May</b>	Month <b>May</b>	Day <b>1</b>	Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>May 18, 1944</b>	9. AGE (in years last birthday) <b>21 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurseryman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tree Nursery</b>		11. BIRTHPLACE (State or foreign country) <b>Johnsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Carl I. Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Rhodes</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 42 9583</b>		17. INFORMANT <b>Mrs. Mary Hamilton (Same as item #2)</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Ruptured Spleen						INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  Subdural + Subarachnoid Hemorrhage							
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  Two car collision							
20c. TIME OF INJURY Hour <b>6 p.m.</b>		Month, Day, Year <b>5-1 1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Mt. Airy - Frederick - MD</b>	(County) <b>Frederick</b>	(State) <b>MD</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>5-2-66</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas Sr. M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5, 1966</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Union Chapel Cemetery</b>		22d. LOCATION (City, town, or county) <b>Nr. Libertytown, Maryland</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR <b>Donald M. Etchison</b>		ADDRESS <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 4 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06923

06914

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Mt. Airy</b>	
d. LENGTH OF STAY IN lb <b>Frederick Mem. Hospital</b>		d. STREET ADDRESS <b>RFD # 1</b>	
3. NAME OF DECEASED (Type or print) <b>James Elwood Hamilton, Jr.</b>		4. DATE OF DEATH <b>May 1 1966</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>Feb. 21, 1952</b>	9. AGE (In years) IF UNDER 1 YEAR <b>14 yrs.</b> Months Deys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick, Md.</b>	11. BIRTHPLACE (State or foreign country) <b>USA</b>
13. FATHER'S NAME <b>James E. Hamilton, Sr.</b>		14. MOTHER'S MAREN NAME <b>Joyce M. Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) --		16. SOCIAL SECURITY NO. --	17. INFORMANT <b>Mrs James E. Hamilton, Sr., Item 2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Tension pneumo-thorax</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Fractured Ribs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Two car collision</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Two car collision</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour <b>6</b> p.m. <b>5-1 1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Highway</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Mt. Airy - Frederick - Md.</b> (County) <b>Mt. Airy - Frederick - Md.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>B.O. Thomas</b>	
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>111 N. Main St. - Frederick, Md.</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas Sr. M.D.</b>		DATE SIGNED <b>5-2-66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Ijamsville Meth.</b>		22d. LOCATION (City, town, or county) <b>Ijamsville, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>John A. Molisunth</b>		24a. REC'D BY REGISTRAR <b>MAY 5 1966</b>	
L.K. Falconer Funeral Home, New Market, Md.		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6924

CERTIFICATE OF DEATH

66915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route 6	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
First MARY (elizabeth) Middle Elizabeth HARGETT		4. DATE OF DEATH Month Day Year May 12 1966	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 22- 1890	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years, last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not available		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-9793D 17. INFORMANT Hugh D. Hargett- Route 6-Frederick-Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		ACUTE CORONARY THROMBOSIS	
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE		6 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from FEBRUARY, 19 66, to MAY, 19 66, that (I) (we) last saw the deceased alive on MAY 12, 19 66, and that death occurred at 95 <sup>o</sup> M. from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 5/12/66	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 804 Toll House Avenue-Frederick-Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16-1966 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	
23d. LOCATION (City, town or county) Frederick, Md. 21701		(State)	
24. FUNERAL DIRECTOR M.R. Etchison & Son- T.		ADDRESS 711 St. Louis 25a. REC'D BY REGISTRAR Frederick, Md. 21701 25b. REGISTRAR'S SIGNATURE MAY 16 1966 Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Part 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6925

CERTIFICATE OF DEATH

06916

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>IDA</b>	Middle <b>MAY</b>	Last <b>HOFFMAN</b> Month Day Year <b>May 25, 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1903</b> 9. AGE (in years (last birthday) <b>62</b> yrs. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>	
13. FATHER'S NAME <b>Thomas Madison Danner</b>		14. MOTHER'S MAIDEN NAME <b>May Hill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>219 20 0601</b>	17. INFORMANT <b>Mrs. Mary Kidwiler, 385 Pearl St. Frederick, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b> 443X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic C.V.D.</b> (c) <b>Hypertensive C.V.D.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jun 17, 1966</b> to <b>May 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1966</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard O. Thomas</b>		22b. DATE SIGNED <b>May 25, 1966</b>	
22c. PHYSICIAN'S NAME, (Type) <b>Bernard O. Thomas, M. D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>228 N. Market Street, Frederick, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Society) <b>Burial</b>	23b. DATE THEREOF <b>May 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	25a. ADDRESS <b>Donald M. Etchison</b>	25b. REC'D BY REGISTRAR <b>MAY 31 1966</b>	25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C6926

## CERTIFICATE OF DEATH

66917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print)	First <b>MAURICE</b>	Middle <b>MILTON</b>	Last <b>HORNER</b>
4. DATE OF DEATH Month <b>MAY</b> Day <b>2</b> Year <b>1966</b>	5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>June 3, 1888</b>
9. AGE (in years last birthday) <b>77</b> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Company</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	13. FATHER'S NAME <b>Charles M. Horner</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Anders</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>213-10-2083</b>		17. INFORMANT <b>Mrs. Orpha A. Horner, LeGore, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBO塞IS</b> 42-1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) 10 yrs. INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/28</b> , 1966, to <b>5/10</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/1</b> , 1966, and that death occurred at <b>5/10</b> A.M. from the causes and on the date stated above.		22b. DATE SIGNED <b>5/2/66</b>	
22a. SIGNATURE <b>Richard C. Reynolds, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> M.E.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Frederick, Maryland</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds, M.D.</b>		23d. LOCATION (City, town or county) (State) <b>LeGore, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/5/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>
24. FUNERAL DIRECTOR <b>Powell &amp; Hartzler, Woodsboro, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>MAY 5 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Frederick		a. STATE D.C.	
b. CITY OR TOWN (if out'sda corporate limits, write RURAL and give nearest town)		b. COUNTY ✓	
Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Washington, D.C.	
Fred Convalescent & Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) JULIAN		4. DATE OF DEATH May 16 1966	
First MIDDLE		Month Day Year	
5. SEX M		9. AGE (in years last birthday) 84 yrs.	
6. COLOR OR RACE W		10. IF UNDER 1 YEAR Months Days Hours Min.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) March 1, 1882	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Arts Engineer Construction Plant, Frederick, Md.		13. FATHER'S NAME Brook J. Jamison	
10b. KIND OF BUSINESS OR INDUSTRY		14. MOTHER'S MAIDEN NAME Susan Hickey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 577-07-1564	
(Yes, no, or unknown) (If yes give war/grades of service)		17. INFORMANT Miss Thelma Ferguson, Walkersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 years +	
1. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		2. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 to May 16, 1966, that (I) (we) last saw the deceased alive on May 16, 1966, and that death occurred at 6:55 P.M., from the causes and on the date stated above.			
22a. SIGNATURE W. J. Riddick		22b. DATE SIGNED May 16, 1966	
22c. PHYSICIAN'S NAME (Type) W. J. Riddick		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Fred. Medical Center		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 5/18/1966		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet	
24. FUNERAL DIRECTOR'S SIGNATURE Y. C. Barton		23d. LOCATION (City, town or county) (State) Frederick Md.	
ADDRESS Walkersville, Md.		25a. REC'D. BY REGISTRAR MAY 20 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**C6928**

**CERTIFICATE OF DEATH**

**06919**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

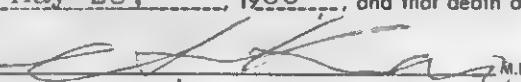
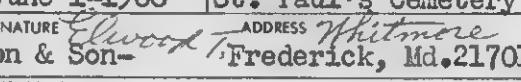
<p>1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b></p> <p>c. LENGTH OF STAY IN 1b <b>66 Yrs.</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b></p> <p>d. STREET ADDRESS <b>307 Rockwell Terrace</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <b>LOUISE VINTON JOLLIFFE</b></p>		<p>First <b>LOUISE</b></p> <p>Middle <b>VINTON</b></p> <p>Last <b>JOLLIFFE</b></p>	<p>4. DATE OF DEATH <b>May 11, 1966</b></p> <p>Month <b>May</b></p> <p>Day <b>11</b></p> <p>Year <b>1966</b></p>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>21 Aug 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Franklin County, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William H. Burkholder</b>		14. MOTHER'S MAIDEN NAME <b>Anna Reed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-54-7887T</b>	
17. INFORMANT <b>Walker N. Jelliffe, Jr. (Same as item #2)</b>		Address	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</p> <p>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.</p> <p style="margin-left: 100px;">DUE TO (b)</p> <p style="margin-left: 100px;">DUE TO (c)</p> <p><i>Cardiac failure, severe arteriosclerosis</i></p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>71 days</b></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5/20, 1966, to 5/11, 1966</b>
20f. (City or town) <b>Frederick</b>		(County) <b>Maryland</b>	(State) <b>21</b>
<p>21. I certify that (I) (the hospital) attended the deceased from <b>5/11, 1966</b>, and that death occurred at <b>12:00 P.M.</b>, from the causes and on the date stated above.</p> <p>22a. SIGNATURE <i>Robert S. Hughes</i></p>			
<p>22b. DATE SIGNED <b>11 May 1966</b></p>			
22c. PHYSICIAN'S NAME (Type) <b>Robert S. Hughes, M. D.</b>		22d. ADDRESS <b>700 Montclaire Ave., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/13/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>
23d. LOCATION (City, town or county) <b>Frederick, Maryland 21701</b>		(State)	
24. FUNERAL DIRECTOR <i>Frank R. Smith</i>		25a. ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>	25b. REC'D BY REGISTRAR <b>MAY 16 1966</b>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06920

1. PLACE OF DEATH a. COUNTY <b>Fredcrick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frderick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Roger</b>	Middle <b>Lee</b>	Last <b>Joy</b>	4. DATE OF DEATH Month <b>May</b>	Month <b>28</b>	Day <b>1966</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21-1901</b>	9. AGE (In years last birthday) <b>64</b> yrs	10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>	12. UNDER 24 HRS Hours <b>0</b>	13. UNDER 24 HRS Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rail Road</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trackman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert McClellan Joy</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Emma Stockman</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-01-3257</b>		17. INFORMANT <b>Robert L. Hanes- Pt. of Rocks, Md. 21777</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH 5 min. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> 2 yrs. DUE TO (c) <b>Chronic Cystitis</b> 2 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan. 24, 1964</b> to <b>May 28, 1966</b> , that I last saw the deceased alive on <b>May 28, 1966</b> , and that death occurred at <b>8:30 A.M.</b> M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>Gum Spring Hollow</b> DATE SIGNED <b>5-28-66</b>								
ACTUAL SIGNATURE 								
PHYSICIAN'S NAME (Type) <b>C.T. Byron Kao, M.D.</b> Brunswick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1-1966</b>		22c. NAME OF CEMETERY OR CEMINATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Point of Rocks- Md. 21777</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS <b>Elwood T. Whitmore</b> 24a. REC'D BY REGISTRAR <b>M.R. Etchison &amp; Son</b> <b>Frederick, Md. 21701</b> DATE <b>JUN 2 1966</b> 24b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>								



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M C D		06921			
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>6 hrs. 14 min</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>13th &amp; East Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Wayne King</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>May 27 1966</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1966</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min <b>6 14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Roger Matz</b>		14. MOTHER'S MAIDEN NAME <b>King, Betty Irene</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mother, Hospital record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16d5</b>		DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Atelectasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6.61</b>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c) <b>IMMaturity</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>While</b>	20f. (City or town) <b>Frederick</b>	(County) (State) <b>Md</b>
21. I certify that (I) attended the deceased from <b>27 May, 1966</b> to <b>27 May, 1966</b> ; that (I) last saw the deceased alive on <b>27 May 1966</b> , and that death occurred at <b>12pm</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>R.L. Guest</b>		22b. DATE SIGNED <b>27 May 66</b>			
22c. PHYSICIAN'S NAME (Type) <b></b>		22d. ADDRESS <b>6 W 3rd ST, Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>RELEASE TO HOSPITAL</b>		23b. DATE THEREOF <b>5/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>FREDERICK MEMORIAL HOSPITAL</b>	23d. LOCATION (City, town or county) (State) <b>FREDERICK MD</b>	
24. FUNERAL DIRECTOR <b>P. D. Deed &amp; Son &amp; Son</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Charles J. Charles J. Charles J.</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06922

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>E.</b>	Last <b>Kinna</b>	
4. DATE OF DEATH	Month <b>May</b>	Day <b>22</b>	Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1897</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Price Electric Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>St. Marks, Frederick, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Edward Kinna</b>	14. MOTHER'S MAIDEN NAME <b>Minnie G. Sulcer</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		
16. SOCIAL SECURITY NO. <b>219 20 2281</b>		17. INFORMANT <b>Mrs. Minnie Kinna (Same as item #2)</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		<i>Metastatic Carcinoma</i> <i>Cardiac arrest of Sigmoid</i>		
INTERVAL BETWEEN ONSET AND DEATH <b>months</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 20g. (County) 20h. (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1, 1966</b> , to <b>May 22, 1966</b> that (I) (we) last saw the deceased alive on <b>May 22, 1966</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.				22b. DATE SIGNED <b>May 22, 1966</b>
22a. SIGNATURE <i>John M. Culler</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN M. CULLER</b>	22d. ADDRESS <b>15 E Second St, Frederick, MD</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 25, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) <b>Frederick, Maryland</b>	(State)
24. FUNERAL DIRECTOR <b>Donald M. Fadley</b>	25a. REG'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE	
M. R. Etchison & Son, Frederick, Maryland		DATE <b>MAY 27 1966</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CC932

## CERTIFICATE OF DEATH

36923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>W. Main St.</b>		d. STREET ADDRESS <b>W. Main St.</b>	
3. NAME OF DECEASED (Type or print) <b>Melvin Leroy Lindsay</b>		4. DATE OF DEATH <b>5 3 1966</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clothing manuf.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>
13. FATHER'S NAME <b>Charles C. Lindsay</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2 214-10-2307</b>	17. INFORMANT Address <b>Mrs. Helen Lindsay, Middletown, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>100%</b>		<i>Adenocarcinoma of Kidney with Metastases</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>(b)</b>		<b>(c)</b>	
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2-1-54</b> to <b>5/3 1966</b> , that (I) (we) last saw the deceased alive on <b>5-3 1966</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Dalton M. Welty</i>		22b. DATE SIGNED <b>5/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY</b>		22d. ADDRESS <b>99 Jefferson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/6/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lutheran Cemetery</b>
23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



14  
FOR STATE  
HEALTH DEPT.

Items 18&20 Film G377 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

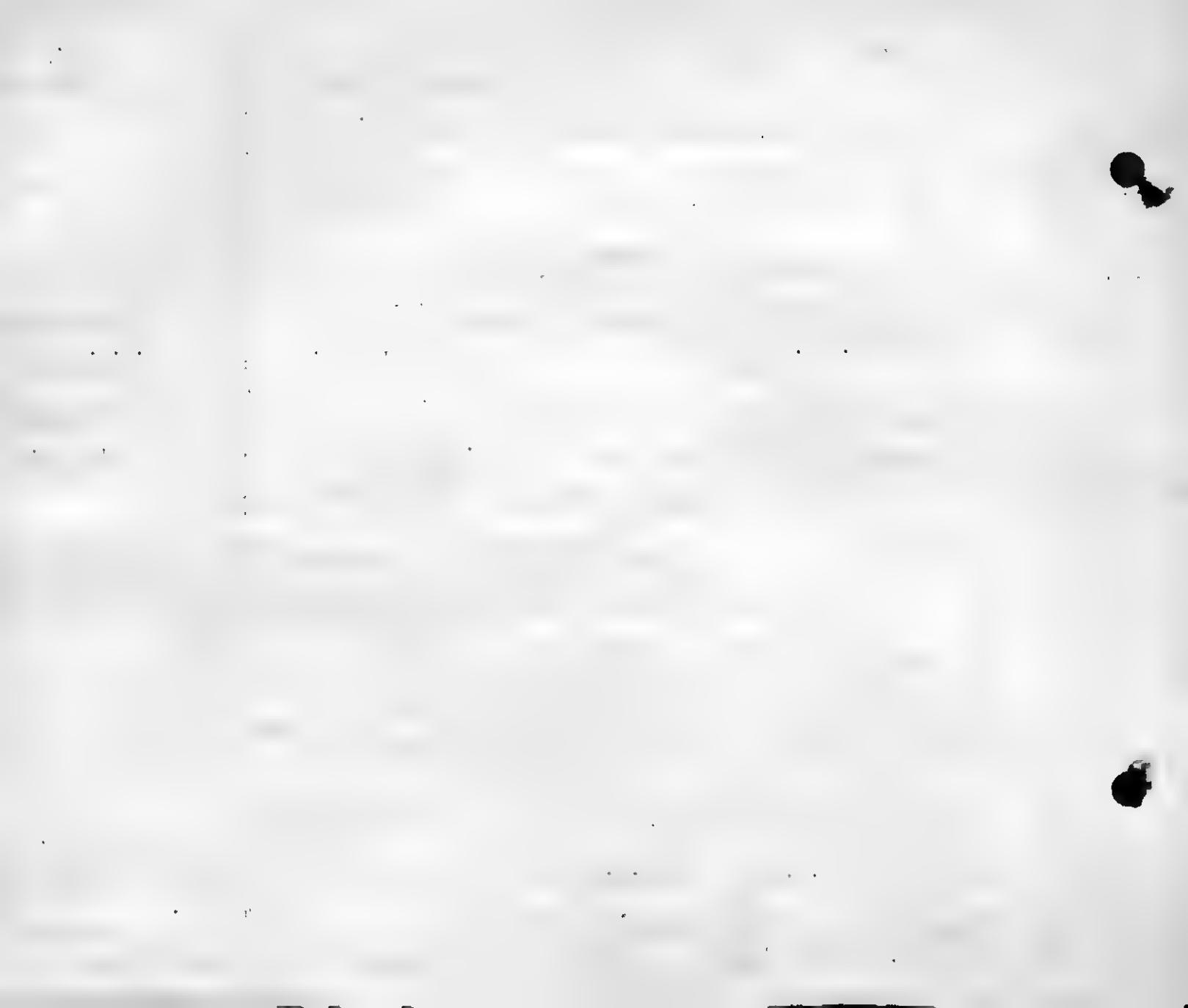
06933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06924

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. STATE Conn. b. COUNTY Fairfield ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethel	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Doa Frederick Memorial Hospital		d. STREET ADDRESS 111 South Street	
3. NAME OF DECEASED (Type or print) First Richard Middle DANIEL J. MANNION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH April 3, 1944	
9. AGE (In years at birthday) 22 yrs.		10. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (State or foreign country) Danbury, Conn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Arthur Mannion		14. MOTHER'S MAIDEN NAME Frances Mulvihill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT John C. Freeland Funeral Home Danbury, Conn.		Address 91 West Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Suffocation Cerebral circulatory insufficiency Acute alcoholism		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Automobile accident over a car resting on neck which was pinned over seat belt off road auto turned over	
20c. TIME OF INJURY Month, Day, Year Hour 5:30 a.m. 5/15/66		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Harney road	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20f. (City or town) Nr. Emittsburg (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE B.O. Thomas		DATE SIGNED 15 May 66	
EXAMINER'S NAME (Type) B.O. Thomas Sr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 5-18-1966		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF 5-18-1966		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		Address (Street, city, town, or county) Bethel, Conn.	
22d. LOCATION (City, town, or county) Bethel, Conn.		(State)	
23. FUNERAL DIRECTOR Robert E. Dailey & Son		24a. REC'D BY REGISTRAR MAY 17 1966	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6934

## CERTIFICATE OF DEATH

06925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as their burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b years		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)			
Frederick		Frederick		MARYLAND		a. STATE Maryland b. COUNTY Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		308 Willow Avenue		d. STREET ADDRESS		308 Willow Avenue			
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle HENRY	Last MARTIN	4. DATE OF DEATH May 19, 1966	Month May	Day 19	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1889	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Newark, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Martin		14. MOTHER'S MAIDEN NAME Margaret Titus							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes		16. SOCIAL SECURITY NO. W.W. I 214-10-1980		17. INFORMANT Mrs. Rose V. Martin		Address 308 Willow Ave. Fred. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> Heart disease with <i>acute myocardial infarct</i> sudden DUE TO <i>Sensitization</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sensitization</i> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR, CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
19									
21. I certify that (I) (this hospital) attended the deceased from ... 8-17-1966 to ... 5-19-1966, that (I) (we) last saw the deceased alive on ... 4-21-1966, and that death occurred at ... 63M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Rex R. Martin</i>		22b. DATE SIGNED 5/19/1966							
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-1966		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Darley &amp; Son</i>		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



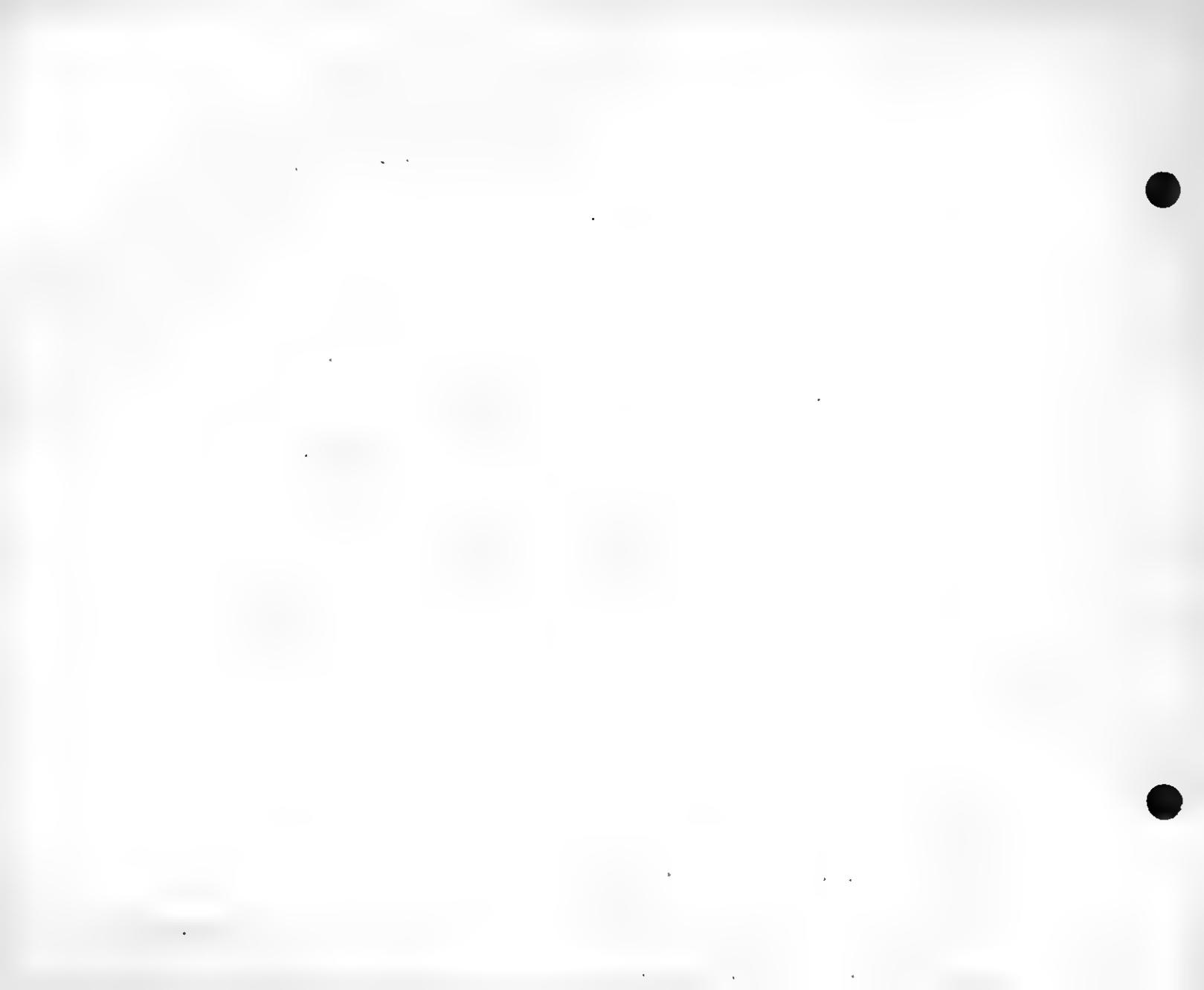
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland		b. CO. NTY Montg.											
b. CITY OR TOWN (If outside corporate lim ts, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate lim ts, write RURAL and give nearest town) Gaithersburg. Rural		d. STREET ADDRESS Rt # 3											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick City Memorial Hosp.						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First Raymond	Middle Venley	Last McConnell	4. DATE OF DEATH	Month May	Year 26th	5. DOY 1956	6. DOY 19	7. MONTH Year 1956	8. DAY Month Days Hours Min								
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. B. DATE OF BIRTH Aug 7th 1942	10. AGE (In years 29 birthday) yrs.	11. IF UNDER 1 YEAR Months Days	12. IF UNDER 24 HRS Hours Min	13. C. T. ZEN OF WHAT COUNTRY U.S.A										
10. USUA. OCCUPAT ON (Give kind of work done during most of working life even if retired) Golf Course Helper		10b. KIND OF BUS NESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) JonesVille. Va.													
13. FATHER'S NAME Albert McConnell						14. MOTHER'S MAIDEN NAME Alpha McConnell.													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 220-40-6666				17. INFORMANT Albert McConnell. As No 2		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9284		Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 10st		Suffocation																	
		Fractured Larynx																	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Kicked by horse				20c. TIME OF INJURY Month, Day, Year Hour 7:30 pm 5-26 1966				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Suloh Ranch		20f. (City or town) Dickerson Frederick Md.		(County) Dickerson Frederick Md.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		B.O. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Jonesville, Va.				22. DATE SIGNED May 26, 1966					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-31-66		23c. NAME OF CEMETERY OR CREMATORIAL McConnell Cemetery		23d. LOCATION (City or Town) Jonesville, Va.		(County) Montgomery Co.		(State) Md.									
24. FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS Ernest C. Gartner, Gaithersburg, Md.		25a. REG'D BY REGISTRAR DATE MAY 31 1966		25b. REGISTRAR'S SIGNATURE Ernest C. Gartner													



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

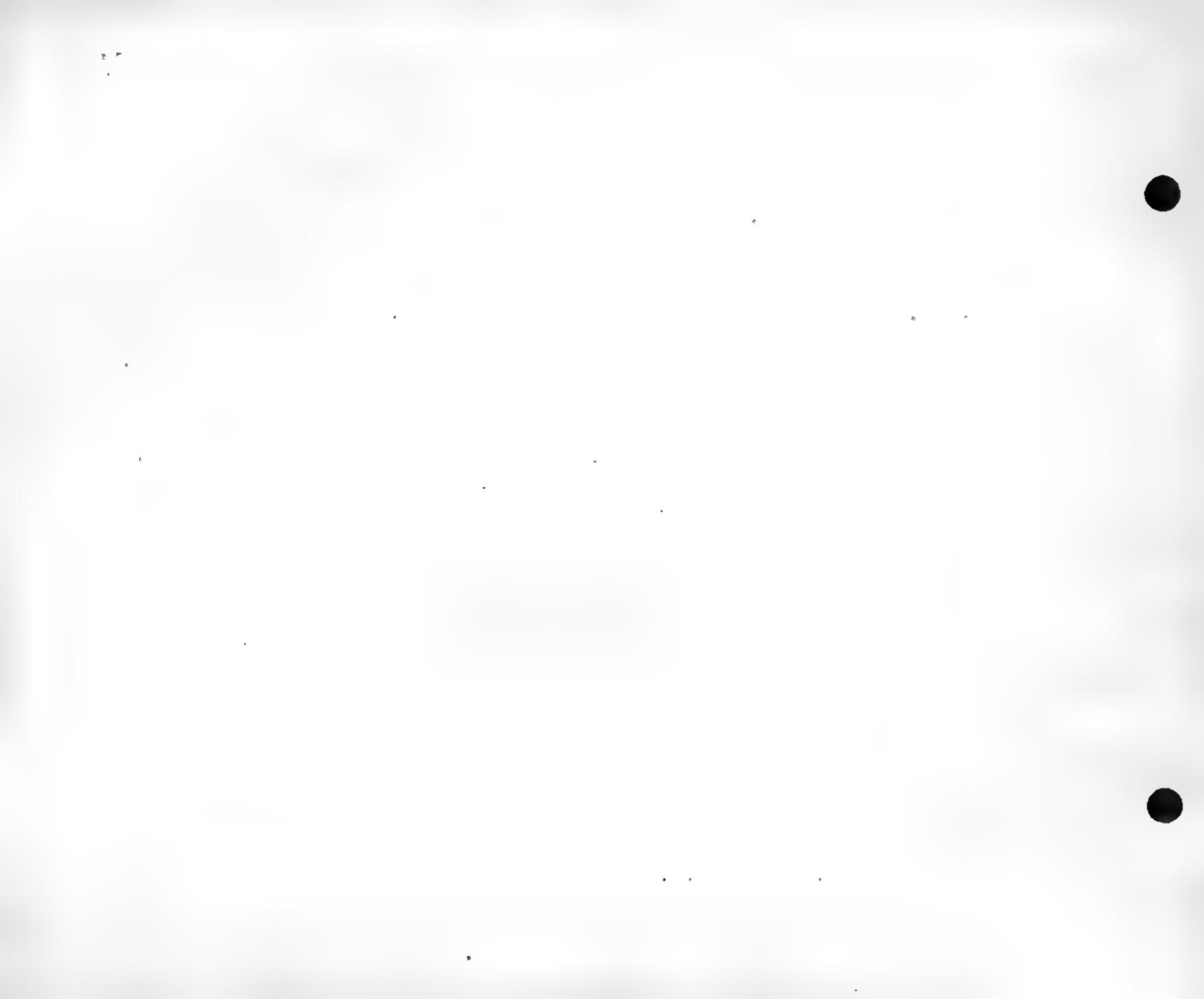
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36938

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06927

1. PLACE OF DEATH a COUNTY <b>Frederick</b>			2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>102 Ninth Ave.</b>			d. STREET ADDRESS <b>same</b>		
3. NAME OF DECEASED (Type or print) <b>LACEY</b>			First <b>HOMER</b>	Middle <b>McGAHA</b>	4. DATE OF DEATH <b>5</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/1898</b>	9. AGE (In years birthday) <b>69</b>
10a. US-AL OCCUPATION (Give kind of work done during most of time prior to death, even if retired) <b>Retired B&amp;O RR-Transfer Dept.</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph McGaha</b>			14. MOTHER'S MAIDEN NAME <b>Belle McKenzie</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WV15-18,5-19214-16-144</b>		
17. INFORMANT <b>Larry Ridgeway Frederick Md,</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>142 x</b>			DUE TO		
			(b) <b>Hypertensive Heart Disease</b>		
			DUE TO		
			(c) <b>Nephrosclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Atrophy - Cerebral Arterosclerosis</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not where at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>(County)</b> <b>(State)</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.					
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>					
22. DATE SIGNED <b>5-21-66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hillsboro Cemetery</b>	
24. FUNERAL DIRECTOR <b>Teete Funeral Home</b>		ADDRESS <b>Brunswick Md.</b>		23d. LOCATION (City or Town) <b>(County)</b> <b>(State)</b> <b>Hillsboro Virginia</b>	
				25e. REC'D BY REGISTRAR	
				25f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
66937					06928				
1. PLACE OF DEATH a. COUNTY Frederick					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					c. LENGTH OF STAY IN 1b years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 315 South Market Street					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
3. NAME OF DECEASED (Type or print) First SAMUEL CLARK Middle MICHAEL Last					4. DATE OF DEATH Month Day Year May 18, 1966				
5. SEX Male 6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brick Works Emp.					10b. KIND OF BUSINESS OR INDUSTRY None				
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Samuel Curtis Michael					14. MOTHER'S MAIDEN NAME Mary Frances Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-10-3427 17. INFORMANT Mrs. Aubrey Baker 114 Catoctin Ave. Fred. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due To Congestive Heart Failure Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Due To (c) Due To Arteriosclerotic Heart disease					INTERVAL BETWEEN ONSET AND DEATH 2 days 6 years.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Peptic ulcer					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19					20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1966, to <u>May 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 18, 1966</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.					22b. DATE SIGNED May 18, 1966				
22a. SIGNATURE <u>Le Roy T. Davis</u>					22c. PHYSICIAN'S NAME (Type) Dr. LeRoy T. Davis M.D. ATTENDING <input checked="" type="checkbox"/> M.D. PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ADDRESS 22d. ADDRESS 22e. LOCATION (City, town or county) (State) 228 North Market Street Frederick, Md. Middletown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF May 20, 1966 23c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery 23d. LOCATION (City, town or county) (State) Middletown, Maryland				
24. FUNERAL DIRECTOR <u>Robert E. Darley &amp; Son</u>					ADDRESS 25a. REC'D BY REGISTRAR MAY 20 1966 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

26938

CERTIFICATE OF DEATH

06929

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Knoxville		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Lenore	Last Miller	4. DATE OF DEATH May 20 1966	Month May	Day 20	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1888	9. AGE (in years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jacob Frye		14. MOTHER'S MAIDEN NAME Unknown Payne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John M. Miller, Jr.		Address Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Carcinoma of the pancreas with generalized abdominal metastases		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1858, 19 to May 20, 1966, that (II) (we) last saw the deceased alive on May 20, 1966, and that death occurred at 8:30 A.M. from the causes and on the date stated above.						22b. DATE SIGNED 20 May 66	
22a. SIGNATURE Henry V. Chase				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Henry V Chase		22d. ADDRESS 415 Church St Frederick Md.					
23a. FURNACE, CREMATION, REMOVAL (Specify) Furnace		23b. DATE THEREOF 5-22-66		23c. NAME OF CEMETERY OR CREMATORIUM Knoxville Cemetery		23d. LOCATION (City, town or county) (State) Knoxville Md.	
24a. FUNERAL DIRECTOR Flete Funeral Home		ADDRESS Brunswick, Md.		24a. REC'D BY REGISTRAR D. MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

66939

CERTIFICATE OF DEATH

06930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown- Rural</b>		d. STREET ADDRESS <b>Route 1</b>					
3. NAME OF DECEASED (Type or print) <b>Ernest Peter Miss</b>		First <b>Ernest</b>		Middle <b>Peter</b>		Last <b>Miss</b>		4. DATE OF DEATH <b>May 24</b>	Month <b>May</b>	Day <b>24</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13-1890</b>	9. AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. HOURS <b>0</b>	13. MIN. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Martin Luther Miss</b>		14. MOTHER'S MAIDEN NAME <b>Alice Cline</b>		15. INFORMANT <b>Mrs. Nellie V. Miss- Route 1- Adamstown-Md.</b>		16. SOCIAL SECURITY NO <b>217-01-5868</b>		17. ADDRESS			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b>		DUE TO (b)		Cerebro Vascular Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		DUE TO (b)		Generalized Arterio Sclerosis		10-20 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Emphysema</b>											
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 8, 1966</b> to <b>May 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 24, 1966</b> , and that death occurred at <b>12:50 P.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <b>Ralph L. Michels</b>		22b. DATE SIGNED <b>May 25-1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Ralph L. Michels</b>		22d. ADDRESS <b>Frederick Medical Center-Frederick-Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 28-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Frederick Mem. Park</b>		23d. LOCATION (City or Town) <b>W. of Frederick, Md.</b>		(County) (State)					
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>	ADDRESS <b>Whitmore Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

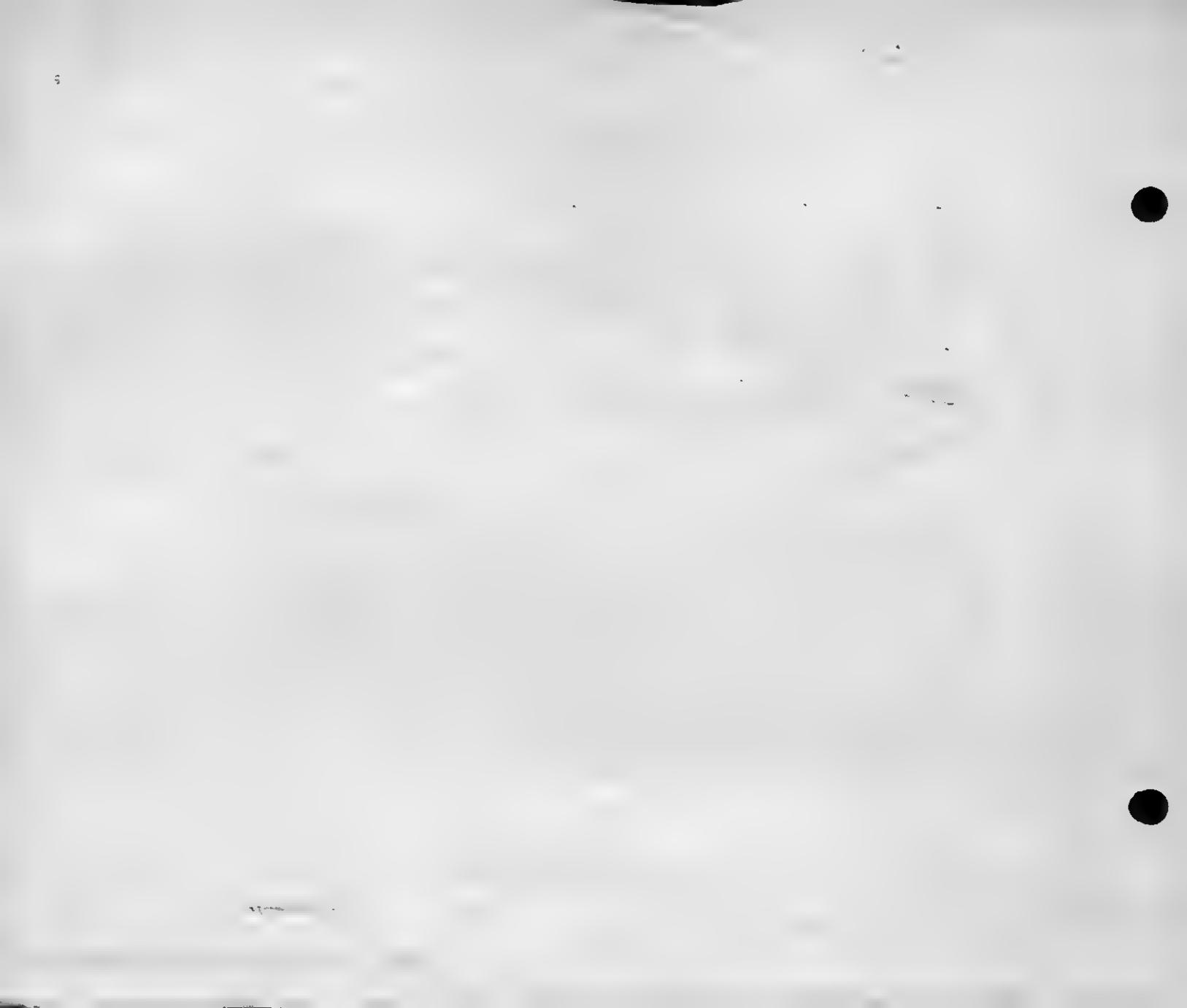
06935

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**CO-FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~in any event~~, within 72 hours after death.

VR A15 (4)  
20M 5-63

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<b>FREDERICK</b>		b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONOCACY HALL NURSING HOME</b>		d. STREET ADDRESS <b>FREDERICK</b>	
3. NAME OF DECEASED (Type or print) <b>NANCY PARSONS</b>		4. DATE OF DEATH <b>MOORE</b> <b>MAY 31 1966</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 28 1873 92 yrs.</b>	
9. DEATH OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE AT HOME</b>		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ST. MARY'S COUNTY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES THOMAS PARSONS</b>		14. MOTHER'S MAIDEN NAME <b>MARIA REEDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>MRS ROBINSON NOTTINGHAM</b> <b>FREDERICK MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.  - 4X DUE TO } (b) } DUE TO } (c)		19. INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>FREDERICK</b> (County) <b>MARYLAND</b> (State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9-13-1966</b> to <b>5-31-1966</b> , that (I) (we) last saw the deceased alive on <b>5-29-1966</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Rex R. Martin</b>		22b. DATE SIGNED <b>5-31-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin</b>		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>FREDERICK, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-3-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>CAPE CHARLES CEM.</b>		23d. LOCATION (City, town or county) <b>CAPE CHARLES, VA.</b> (State) <b>VA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SALAMONE FUNERAL HOME</b>		25a. ADDRESS <b>FREDERICK, MD.</b>	
25a. REC'D BY REGISTRAR <b>JUN 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, then please, remove carbon papers, Pages 1 and 2, from this certificate, page 3 should be detached for use as the burial-transit permit. Then please, return carbon papers, Pages 1 and 2, to the funeral director, page 3 should be detached for use as the burial permit. Then please, remove, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06932
CERTIFICATE OF DEATH												
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY			a. STATE									
Frederick			Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			b. COUNTY									
Frederick			Frederick									
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
Weeks			Route #1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS									
Frederick Nursing & Conv. Center			Ijamsville, Maryland									
e. IS RESIDENCE ON A FARM?												
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	12	19	66		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.	Months	Days	Hours	Min.	
Female	White	WIDOWED	DIVORCED	March 4, 1893	73 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)									12. CITIZEN OF WHAT COUNTRY?	
Housewife	*****	Reels Mill, Maryland									U. S. A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME											
Jacob J. Wilcom	Isabelle Hane											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address									
No	218 38 1600	Francis S. Murphy, Route # 1, Ijamsville, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis												
DUE TO (b) Severe Arteriosclerosis												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	May 12						
19	Not While at work											
21. I certify that (I) (this hospital) attended the deceased from	21. I certify that (I) (this hospital) attended the deceased from (April 1, 1966, to May 12, 1966, that (I) (we) last saw the deceased alive on May 4, 1966, and that death occurred at 5:15 A.M. from the causes and on the date stated above.)											
22a. SIGNATURE	22b. DATE SIGNED											
<i>Austin Pearson</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> May 13, 1966											
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS											
Austin A. Pearson, M. D.	4 East Church Street, Frederick, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county) (State)									
Burial	May 14, 1966	Mount Olivet Cemetery	Frederick, Maryland									
24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE										
Howard M. Etchison & Son, Frederick, Maryland	MAY 16 1966	<i>Charles Judge</i>										



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1  
**16942**

**CERTIFICATE OF DEATH**

**06933**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b <i>2 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Frederick</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>R 6</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALVIE CHARLES NUSBAUM</b>		4. DATE OF DEATH <i>May 9 1966</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 10, 1907</i>	
9. AGE (In years) <b>64</b> (last birthday) <b>64</b> yrs.		10. IF UNDER 2 YEARS <input type="checkbox"/> Months <b>0</b> Days <input type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry E. Nusbaum</i>		14. MOTHER'S MAIDEN NAME <i>Susie Lochner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <i>216-22-9823</i>	
17. INFORMANT <i>Alvie A. Nusbaum, Jr., Fred. R 6, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN DNSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the lung</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____		DUE TO (c) _____	
DUE TO (b) _____		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(this hospital)</b> attended the deceased from saw the deceased alive on <b>3/9 1966</b> , and that death occurred at <b>10 AM</b> , M, from the causes and on the date stated above.		21b. DATE SIGNED <i>5/9/66</i>	
22a. SIGNATURE <i>Robert S. Hughes</i>		22b. DATE SIGNED <i>5/9/66</i>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT S. HUGHES</b>		22d. ADDRESS <i>303 W. College Ter., Fred., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/15/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Hope Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Woodsboro Md.</i>	
24. FUNERAL DIRECTOR <i>J.C. Barton, Walkersville, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 16 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36943

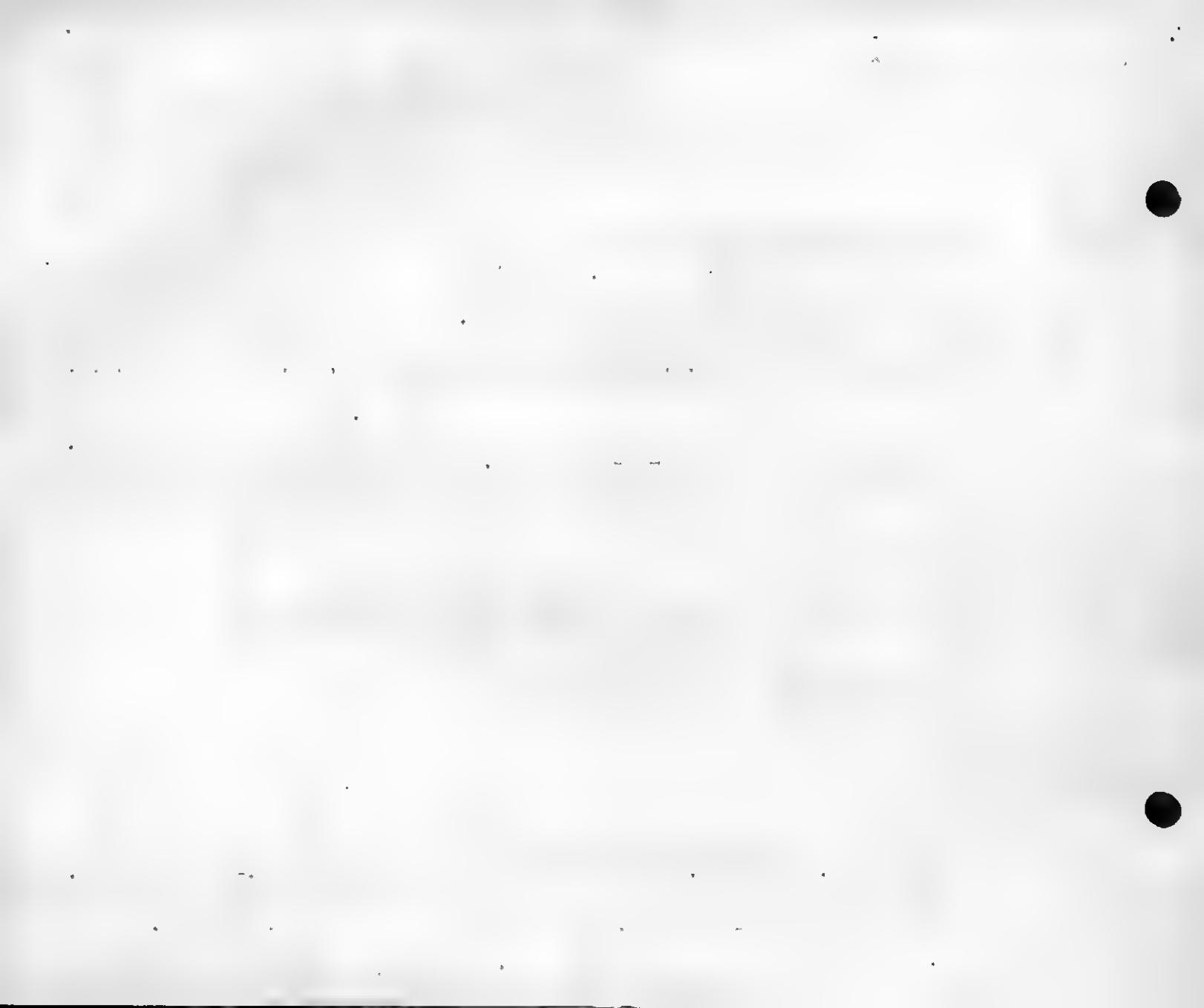
## CERTIFICATE OF DEATH

06934

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>12 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Route 6</b>	
3. NAME OF DECEASED (Type or print) <b>Oscar M. O'Hara</b>		4. DATE OF DEATH <b>May 29- 1966</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>
9. B. DATE OF BIRTH <b>Feb. 17- 1894</b>		9. AGE (In years last birthday) <b>72 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.R. Signalman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John O'Hara</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Baer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWar 1</b>		16. SOCIAL SECURITY NO. <b>705-07-4593</b>	
17. INFORMANT <b>Mrs. Goldie Cook O'Hara-Route 6-Frederick</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute coronary thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> 5 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>12/16</b> , 19 <b>66</b> to <b>5/29</b> , 19 <b>66</b> that <input type="checkbox"/> (we) last saw the deceased alive on <b>5/28</b> 19 <b>66</b> , and that death occurred at <b>12:30</b> M from causes and on the date stated above.		20f. (City or town) <b>Frederick</b> (County) <b>Md.</b> (State) <b>MD</b>	
22a. SIGNATURE <b>Richard C. Reynolds</b>		22b. DATE SIGNED <b>May 30-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>		22d. ADDRESS <b>804 Toll House Ave.-Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son - T.</b>		ADDRESS <b>Frederick, Md. 21701</b>	23d. LOCATION (City or Town) <b>Frederick, Md. 21701</b> (County) <b>Md.</b> (State) <b>MD</b>
25a. REC'D BY REGISTRAR <b>DAJUN</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1 M  
FOR STATE  
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06935

1. PLACE OF DEATH  
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1B

Hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

JOHN

EDWARD

OVERS

First Middle

Last

4. DATE  
OF  
DEATH

May 14

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED  NEVER MARRIED

WIDOW

DIVORCED

8. DATE OF BIRTH

Nov. 25-1908

9. AGE (In years  
last birthday)

57 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

勞工 - Const.

10b. KIND OF BUSINESS OR INDUSTRY

\*\*\*\*\*

11. BIRTHPLACE (State or foreign country)

Frederick Co. Maryland

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

James Overs

14. MOTHER'S MAIDEN NAME

Pauline Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank and date of service)

Yes

W.W.II

16. SOCIAL SECURITY NO. 17. INFORMANT

217-05-0885

Russell Overs-104 Carver Apts

Address Frederick, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute Congestive Heart Failure  
Massive R. Cerebral Hemorrhage  
Essential Hypertension

INTERVAL BETWEEN  
ONSET AND DEATH

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.

20d. INJURY OCCURRED  
While  Not While   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

B.O.Thomas

EXAMINER'S  
NAME (Type)

B.O.Thomas Sr., M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

S-14-66

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 18-66

22c. NAME OF CEMETERY OR CREMATORI

Hopewell

22d. LOCATION (City, town, or county)

Frederick Co. Md.

23. FUNERAL DIRECTOR

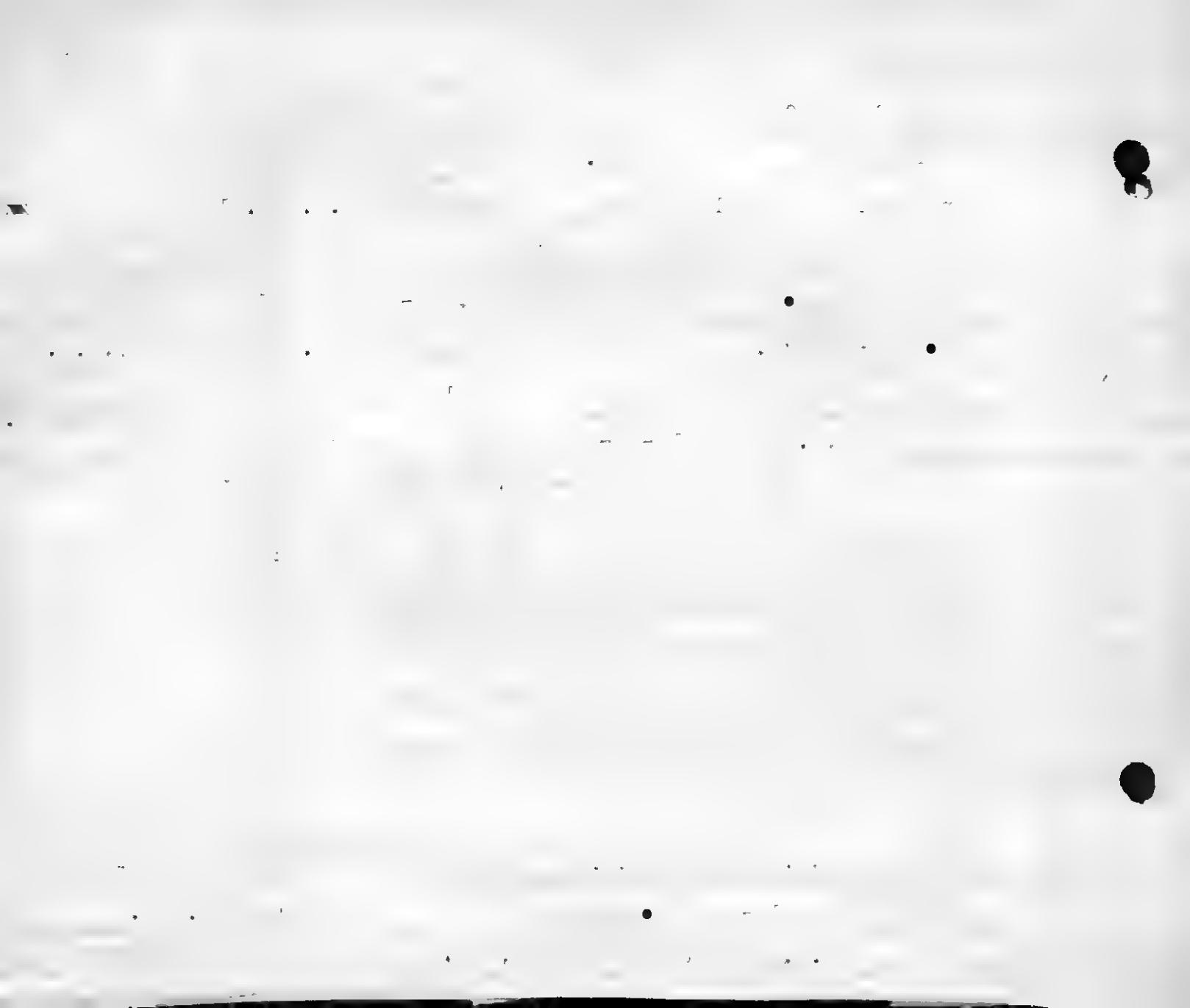
C.E.Hicks 111 Frederick, Md.

24a. REG'D BY REGISTRAR

MAY 17 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36945

CERTIFICATE OF DEATH

06936

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>219 East Church Street</b>		d. STREET ADDRESS <b>219 East Church Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GRAYSON</b>		First <b>W.</b>	Middle <b>PHELPS</b>	Last <b>May</b>	Month <b>25</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>DIVORCED</b>	8. DATE OF BIRTH <b>February 5, 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eveready Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Friendship, Carroll, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Winfield S. Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Mary Becroft</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220 05 5565</b>		17. INFORMANT <b>Mrs. Mary Phelps (Same as item #2)</b>		Address	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Fulmonary emphysema with chronic bronchitis &amp; cor pulmonale</i> DUE TO <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Senility</i> (c) <i></i></p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p><i>Spastic colon with diarrhea</i></p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>pm</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>9-29-1958</b> to <b>5-25-1966</b>, that (I) (we) last saw the deceased alive on <b>5-24-1966</b>, and that death occurred at <b>815P</b> M, from causes and on the date stated above.</p>							
22a. SIGNATURE <i>Rex R. Martin</i>		22b. DATE SIGNED <b>May 26, 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin</b>		22d. ADDRESS <b>220 N. Market Street, Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>		ADDRESS <i>1100 Frederick St., Frederick, Maryland</i>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 Item 18 Film G377 6/9 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH												06937	
1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b				b. COUNT Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				d. STREET ADDRESS West Potomac Street					
3. NAME OF DECEASED (Type or print) Walter				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX M				6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman's Engineer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Morgan S. Rice				14. MOTHER'S MAIDEN NAME Margaret A. Gorsuch									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no				16. SOCIAL SECURITY NO. 213 09 4438				17. INFORMANT Margaret Mahoney				Address California Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621													
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO (b) Squamous cell cancer - Bronchogenic	
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 6 May, 1966, to 25 May, 1966, that (I) (we) last saw the deceased alive on 25 May 1966, and that death occurred at 740 M, from the causes and on the date stated above.												22b. DATE SIGNED	
22a. SIGNATURE Henry V. Chase												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 25 May 66	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase												22d. ADDRESS 4E, Church St. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-27-66				23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park				23d. LOCATION (City, town or county) Baltimore	
24. FUNERAL DIRECTOR Fette Funeral Home				ADDRESS Brunswick, Md.				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
DA MAY 27 1966												Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT M

00947

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06938

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN lb <b>years</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 East Third Street</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
f. STREET ADDRESS <b>324 East Third Street</b>			g. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
h. NAME OF DECEASED (Type or print) <b>First MILTON Middle LUTHER Last SHOCK</b>			i. DATE OF DEATH <b>May 3, 1966</b>				
j. SEX <b>Male</b> k. COLOR OR RACE <b>White</b>			l. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
m. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Plastering Cont.</b>			n. KIND OF BUSINESS OR INDUSTRY <b>Plasterer</b>				
o. FATHER'S NAME <b>Daniel Howard Shook</b>			p. MOTHER'S MAIDEN NAME <b>Harriet Ann Kintz</b>				
q. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No <b>XXXXXXXXXXXX</b>			r. SOCIAL SECURITY NO <b>219/12/8223</b>				
s. INFORMANT <b>Mrs. Rae H. Shook 324 E. 3rd St. Frederick, Md.</b>			t. ADDRESS				
u. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Influenza</b> DUE TO (c)						v. INTERVAL BETWEEN ONSET AND DEATH	
w. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						x. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
y. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			z. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
aa. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>			bb. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			cc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>	
dd. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						ee. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Dr. B. O. Thomas, Sr. M.D.</b>	
ff. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			gg. DATE THEREOF <b>May 6, 1966</b>			hh. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	
ii. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>			jj. RECD BY REGISTRAR <b>MAY 6 1966</b>			kk. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ll. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>						mm. ADDRESS <b>Frederick, Maryland</b>	
nn. ATIME (5) 6M 1/66						oo. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

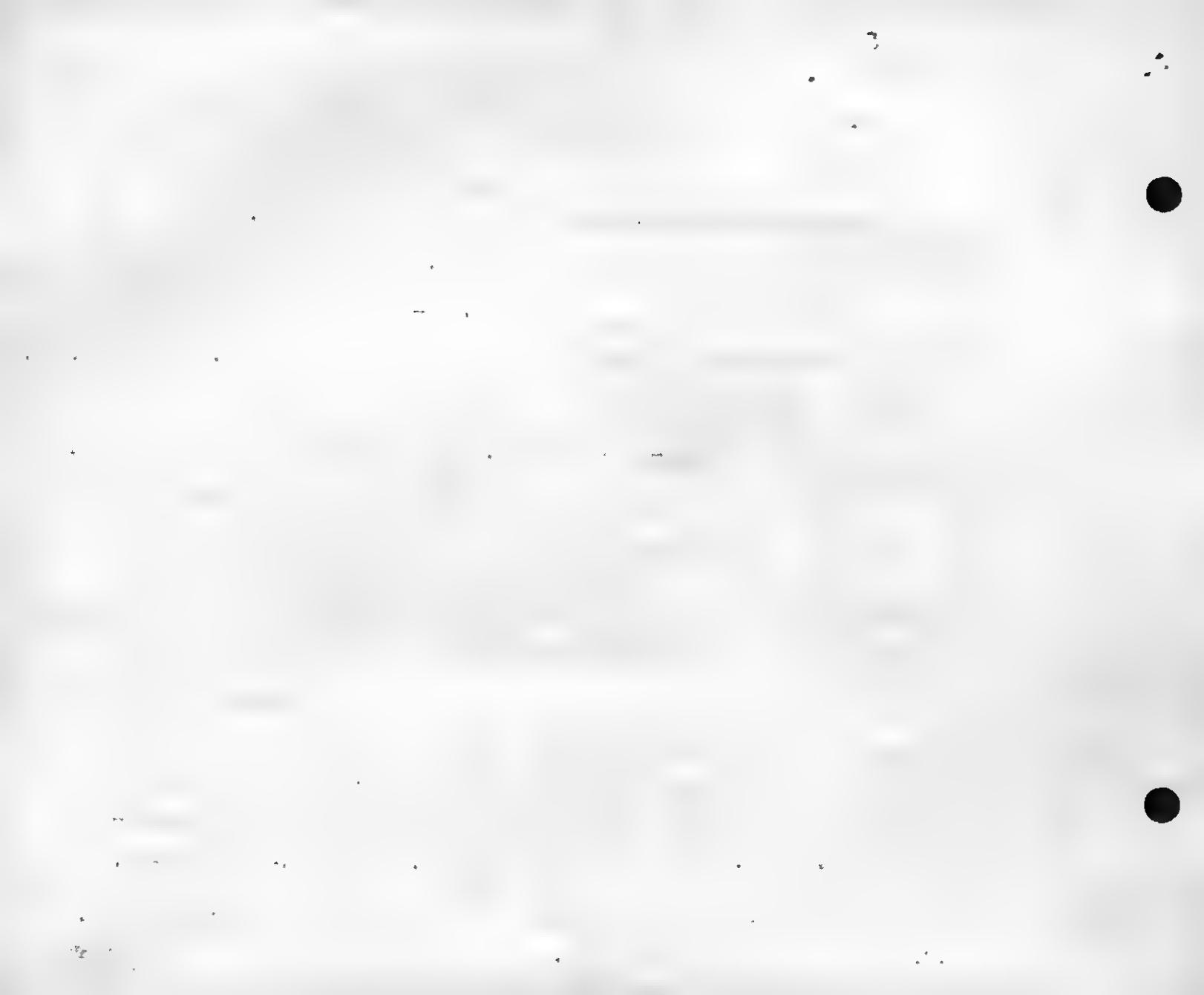
CERTIFICATE OF DEATH

06939

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CC948			1								
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)								
a. COUNTY <b>Frederick</b> MARYLAND			a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Frederick</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>			d. STREET ADDRESS <b>19 Taney Apts.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>George Earl Stull- Sr.</b>			First <b>George</b> Middle <b>Earl</b> Last <b>Stull- Sr.</b>		4. DATE OF DEATH <b>May 8- 1966</b>		Month <b>May</b> Day <b>8-</b> Year <b>66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>Jan. 25- 1896</b>		9. AGE (In years (last birthday) <b>70 yrs</b> )			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Plating Machine Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) <b>Frederick County- Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Stull</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Angleberger</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>Wwar 1 214- 10- 5187</b>			17. INFORMANT <b>Mrs. Harvey Blank-Route 7-Frederick-Md.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arterio-sclerotic heart disease + coronary</i> days									INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO (b) <i>Pulmonary emphysema + chronic bronchitis</i> 10 yrs								
			DUE TO (c) <i>Partial Intestinal Obstruction-? cause</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>10-8-1966</i>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>10-8-1966</b> to <b>5-8-1966</b> , that (I) (we) last saw the deceased alive on <b>5-8-1966</b> , and that death occurred at <b>8:15 PM</b> , from causes and on the date stated above.											
22a. SIGNATURE <i>Rex R. Martin</i>									22b. DATE SIGNED <b>May 9-1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>			22d. ADDRESS <b>220 N. Market St.-Frederick-Md. 21701</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 11- 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Rocky Springs Cemetery</b>		23d. LOCATION (City or Town) <b>West of Frederick, Md.</b>		(County) (State)			
24. FUNERAL DIRECTOR <i>Elwood T. Whitmore</i> <b>M.R. Etchison &amp; Son- Frederick, Md. 21701</b>						25a. REC'D BY REGISTRAR <b>MAY 13 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit.  Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Frederick				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle town-Rural				c. LENGTH OF STAY IN 1b 6 Yrs.				b. COUNTY Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Valley View Nursing Home								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market					
10. 1				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First KEMP	Middle DUDLEY	Last SWECKER		4. DATE OF DEATH May 27, 1966		Month May	Day 27	Year 1966			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 July 1878		9. AGE (In years last birthday) 87 yrs.	10. FUNDER 1 YEAR Months Days		11. FUNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Minister				10b. KIND OF BUSINESS OR INDUSTRY Minister of the Gospel				11. BIRTHPLACE (County & State, or foreign country) Dunmore, W. Va.				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Christopher B. Swecker				14. MOTHER'S MAIDEN NAME Nebraska D. Jackson									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No.		17. INFORMANT 220-44-6286		Address Mrs. Nancy Watkins, New Market, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> 4201 DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Years</i>												INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Dealt in militia</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dunmore		(County) West Virginia		(State) Md.				
21. I certify that (I) (this hospital) attended the deceased from <i>5/4</i> , 1966, to <i>5/5</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/4</i> , 1966, and that death occurred at <i>5:05 P.M.</i> , from the causes and on the date stated above.				22b. DATE SIGNED 28 May 1966									
22a. SIGNATURE <i>James B. Thomas</i>				22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.									
22d. ADDRESS 228 N. Market St., Frederick, Md. 21701													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/66	23c. NAME OF CEMETERY OR CREMATORIUM Dunmore Cemetery		23d. LOCATION (City, town or county) Dunmore, West Virginia						(State)		
24. FUNERAL DIRECTOR <i>Frank R. Etchison</i>		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701	25a. REC'D BY REGISTRAR DATE MAY 31 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and is any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)		a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
				2 hrs.		Thurmont		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Memorial Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
				3 Carroll St		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
HARRY		Edgar		VALENTINE	14 MAY	3	1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
male		white		June 5, 1896	69 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Civil Service			Retired		Maryland		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
Harvey Valentine			Annie B. Troxell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes		WW1 218-09-5904		Marie Valentine		3 Carroll St. Thurmon		
Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4-1 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS								
INTERVAL BETWEEN ONSET AND DEATH 24 hours								
20a. MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/3, 1966 to 5/3, 1966, that (I) (we) last saw the deceased alive on 5/3, 1966, and that death occurred at 5 1/2 M. from the causes and on the date stated above.		22a. SIGNATURE Richard C. Reynolds 22b. DATE SIGNED 5/3/66						
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Richard C. Reynolds 804 Toll House Ave. Frederick, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)		
Burial		5-7-66		Mt. Tabor Cemetery		Rocky Ridge Md. Fred. C.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Raymond S. O'reagan		Thurmont, Md.		DATE MAY 5 1966		Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>	First <b>M</b>	Middle <b>ELLEN</b>	Last <b>WARNER</b>
4. DATE OF DEATH <b>May 6 1966</b>	Month <b>May</b>	Day <b>6</b>	Year <b>1966</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 12, 1877</b>
9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS <b>88 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>	11. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	12. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>LEWIS H CANTWELL</b>	14. MOTHER'S MAIDEN NAME <b>SARAH GREEN</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>316-54-7856</b>	17. INFORMANT <b>STERLING WARNER</b>	Address <b>LEWISTOWN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> <i>Cerebral thrombosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bilateral bronchopneumonia</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> to <b>May 6 1966</b> , that (I) (we) last saw the deceased alive on <b>May 6 1966</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Ernest A. Dettbarn</i>		22b. DATE SIGNED <b>May 6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST A DETTBARN</b>		22d. ADDRESS <b>Wadsworth, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/9/66</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>PIPE CREEK</b>		23d. LOCATION (City, town or county) (State) <b>CARROLL CO MD</b>	
24. FUNERAL DIRECTOR ADDRESS <b>DD Hartzler &amp; Sons New Windsor</b>		25a. REC'D BY REGISTRAR <b>CHARLES JUDGE</b>	
		25b. REGISTRAR'S SIGNATURE <b>CHARLES JUDGE</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

26952

CERTIFICATE OF DEATH

06943

1. PLACE OF DEATH a. COUNTY	Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Frederick		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Frederick Memorial Hospital		Several Hrs. s. Emmitsburg RD 1.	d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)	First Laura	Middle Louise	Last Warthen	4. DATE OF DEATH	Month May Day 20 Year 1966

5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years, last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Female	White	WIDOWED	<input checked="" type="checkbox"/>	April 5, 1896	70 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Housewife			Own Home			Frederick Co.			USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Thomas Eugene Warthen	Louis P. O'Toole		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	215-10-8933	Mrs. J.W. Wetzel	Frederick, Md. RD 3

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	Carinomatosis of the abdomen 2 mo.
DUE TO (b)	original source undetermined
DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
Obstructive jaundice	

20a. ACCIDENT WAS UNDERLYING	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
OR CONTRIBUTING	CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a.m.		While at work	Not While at work			
p.m.	19					

21. I certify that (I) (this hospital) attended the deceased from 30 May, 1966, to 30 May, 1966, that (I) (we) last saw the deceased alive on 30 May, 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

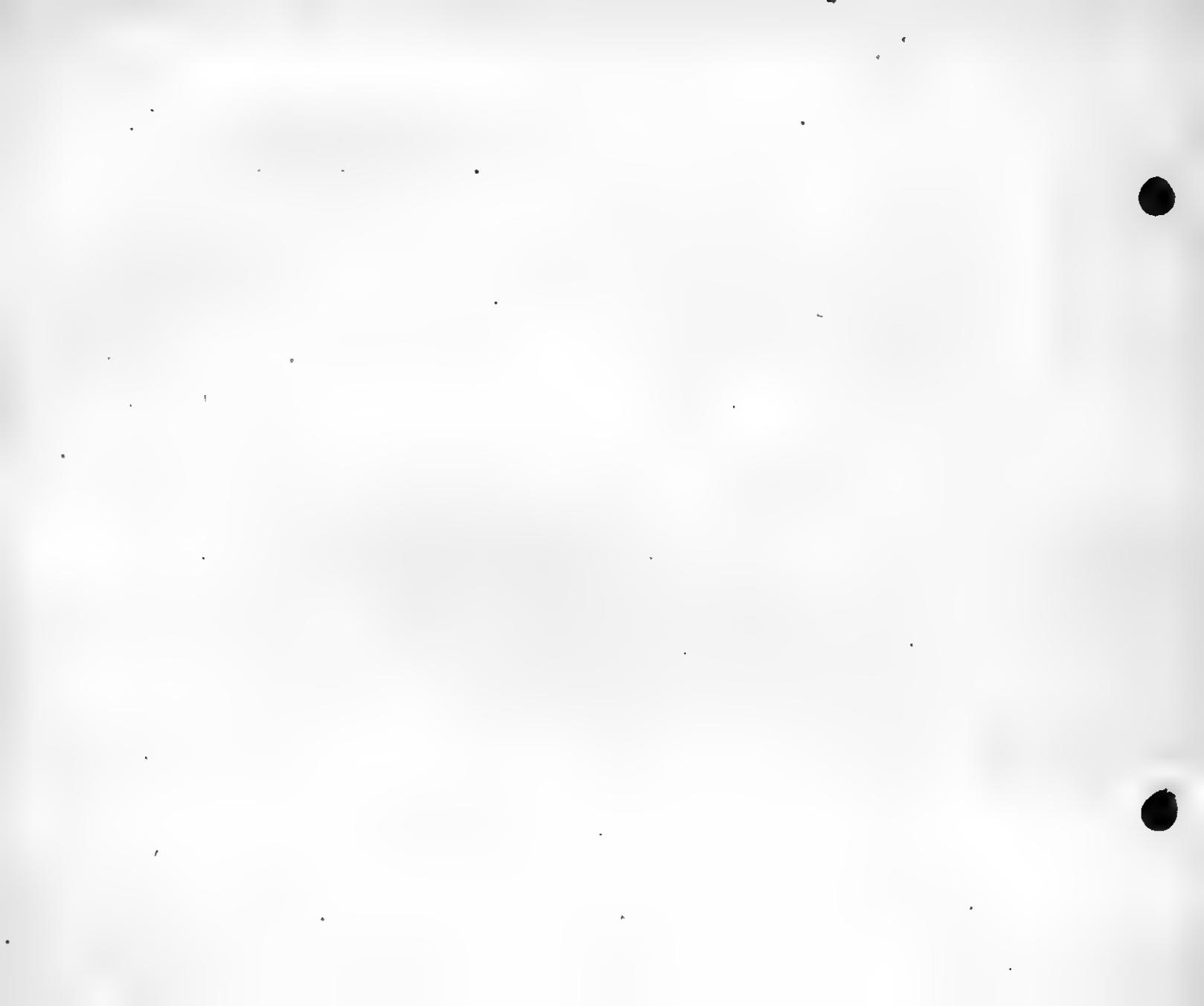
Henry V. Chase

22b. DATE SIGNED

20 May 66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county)	(State)
Henry V. Chase	4E Church St Frederick, Md.	St. Anthony Cemetery	Nr. Emmitsburg	Fred. Co.

23a. BURIAL/CREMATION, DATE THEREOF	23b. REMOVAL (Specify)	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county)	(State)
Burial	5-24-66	St. Anthony Cemetery	Nr. Emmitsburg	Fred. Co.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	Md.
Raymond E. Creager	Thurmont, Md.	MAY 24 1966	Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36953

CERTIFICATE OF DEATH

66944

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>807 S. Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Roger</b>	Middle T.	Last <b>Webb</b>
4. DATE OF DEATH Month Day Year	May 14, 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1906
9. AGE (In years last birthday) 60 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harry R. Webb</b>	14. MOTHER'S MAIDEN NAME <b>Nellie Dorsey</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>215-14-2794</b>	17. INFORMANT Mrs. Ruth S. Webb 807 S. Main St., Mt. Airy, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5/11 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Acute Cardiac Arrhythmia</b> <b>Congestive Heart Failure</b> <b>Pulmonary Embolism</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 3, 1966</b> , to <b>May 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1966</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Stone</b>	M.D. ATTENDING PHYS. <input type="checkbox"/>	22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Frederick, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/17/1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <b>Mt. View Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Union Bridge, Md.</b>
24. FUNERAL DIRECTOR <b>C. H. Waltz Box 241 Sykesville, Md.</b>	25a. REC'D BY REGISTRAR <b>MAY 18 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1 M  
FOR STATE  
HEALTH DEPT.

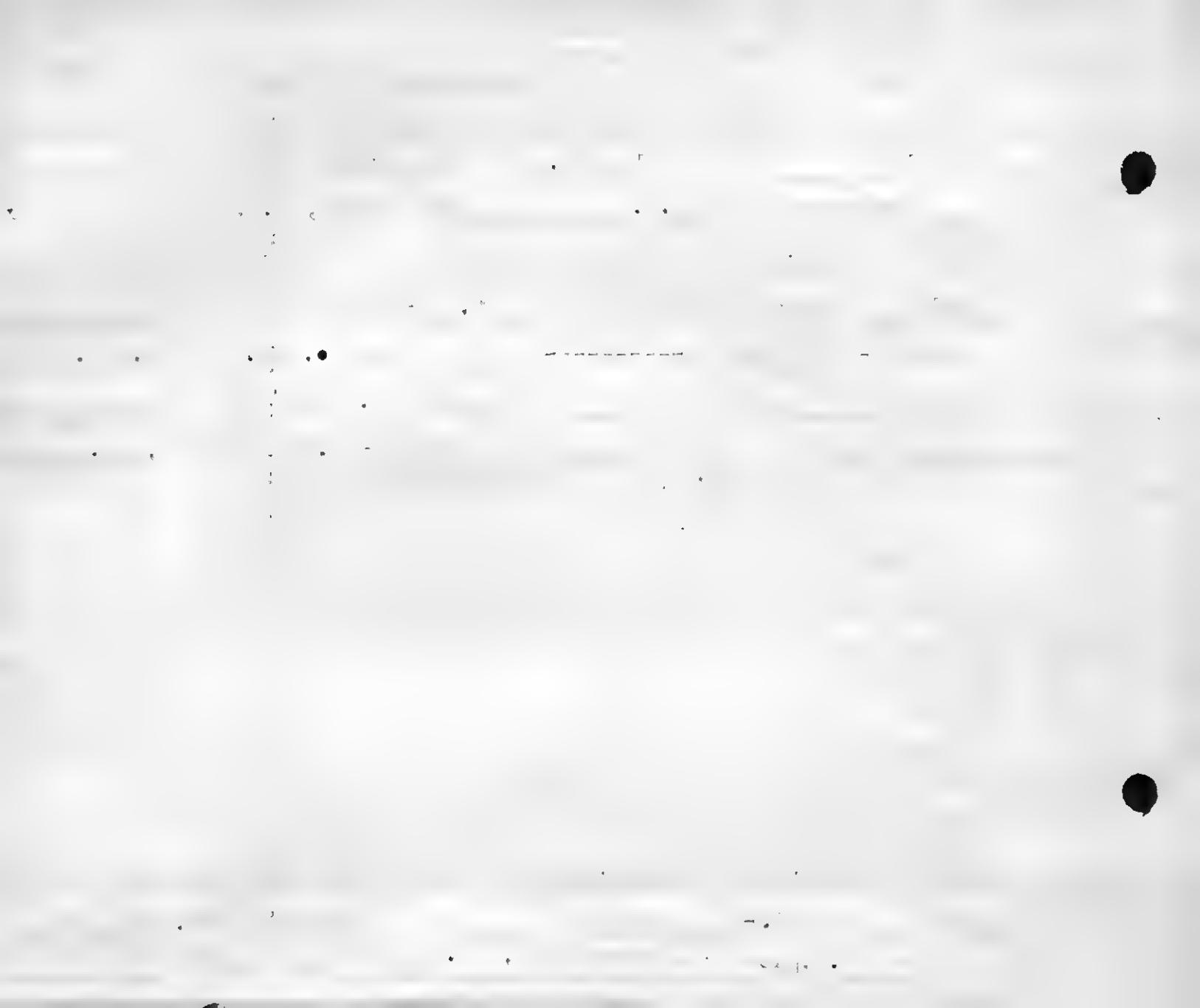
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16954 06945

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland b. COUNTY Frederick	
Rural		12 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Buckeystown P.O.		Buckeystown Rural	
3. NAME OF DECEASED (Type or print)		First HARVEY	Middle AUGUSTUS	4. DATE OF DEATH	Month May Day 11 Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
Male Negro		WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 22-1902	63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer - Brickyard				Frederick Co., Md. 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
GEORGE H. WEEDON		LAURA J. WOOD		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Ernest Weedon-Rt. 2 Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive Heart Failure			
7201 DUE TO		Left Ventricular Aneurysm			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Atherosclerotic Heart Disease			
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE B.O. Thomas				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas Sr. M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16-66		22c. NAME OF CEMETERY OR CREMATORIUM Hopehill	
22d. LOCATION (City, town, or county) Frederick Co., Maryland				(State)	
23. FUNERAL DIRECTOR C.E. Hicks III		ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR MAY 17 1966	
				24b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06955

## CERTIFICATE OF DEATH

06946

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRUNSWICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>814 Second Avenue</b>		d. STREET ADDRESS <b>same</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH 5 2 1966	
3. NAME OF DECEASED (Type or print)	First <b>ROBERT</b>	Middle <b>LEE</b>	Last <b>WENNER</b>
S. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>Robert J. Wenner</b>		14. MOTHER'S MAIDEN NAME <b>Margaret J. Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>318-30-8639</b>	17. INFORMANT Address <b>Mrs. Ada Lewis Wenner-Brunswick, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Anterior atherosclitic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
DUE TO (b) DUE TO (c) Generalized atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jefferson</b>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5-22-1966</b> to <b>5-22-1966</b> , that (I) (we) last saw the deceased alive on <b>5-22-1966</b> , and that death occurred at <b>2:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Charles E. Pruitt</i>		22b. DATE SIGNED <b>5-22-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles E. Pruitt M.D.</b>		22d. ADDRESS <b>Brunswick Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL <b>1</b>	23b. DATE THEREOF <b>5/4/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Lutheran Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Jefferson Fred. Md.</b>
24. FUNERAL DIRECTOR <b>Leete Funeral Home</b>	ADDRESS <b>Brunswick, Maryland</b>	25a. REC'D BY REGISTRAR DATE <b>MAY 5 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06956

06947

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE North Carolina		COUNTY Alleghany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Airy		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparta		70-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Frederick Memorial Hospital		d. STREET ADDRESS ?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JESSE		First	Middle	Last	4. DATE OF DEATH MAY 1, 1966	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1881	9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Alleghany Co. Nor. Car.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Wyatt		14. MOTHER'S MAIDEN NAME America ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service) No		16. SOCIAL SECURITY NO. XXXXXX		17. INFORMANT Sturdivant Funeral Home		Address Sparta, N. Car.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Ruptured Aorta Fractured Stemum + Ribs		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision		20c. TIME OF INJURY Month, Day, Year Hour am. 5-7 1966 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Mt. Airy - Frederick Rd.		20g. (County) Alleghany		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER B.O. Thomas		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-2-66		
ACTUAL SIGNATURE B.O. Thomas		EXAMINER'S NAME (Type) B.O. Thomas Sr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 5/4/1966		22c. NAME OF CEMETERY OR CREMATORIAL New Salem Cemetery		22d. LOCATION (City, town, or county) Whitehead, North Carolina		(State)
23. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR MAY 6 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		

